

Opipramol dihydrochloride

sc-255404

Material Safety Data Sheet



The Power to Question

Hazard Alert Code
Key:

EXTREME

HIGH

MODERATE

LOW

Section 1 - CHEMICAL PRODUCT AND COMPANY IDENTIFICATION

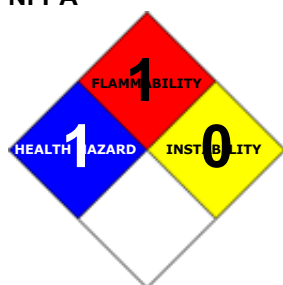
PRODUCT NAME

Opipramol dihydrochloride

STATEMENT OF HAZARDOUS NATURE

CONSIDERED A HAZARDOUS SUBSTANCE ACCORDING TO OSHA 29 CFR 1910.1200.

NFPA



SUPPLIER

Company: Santa Cruz Biotechnology, Inc.

Address:

2145 Delaware Ave

Santa Cruz, CA 95060

Telephone: 800.457.3801 or 831.457.3800

Emergency Tel: CHEMWATCH: From within the US and
Canada: 877-715-9305

Emergency Tel: From outside the US and Canada: +800 2436
2255 (1-800-CHEMCALL) or call +613 9573 3112

PRODUCT USE

■ CAUTION: May modify behaviour and state of alertness; exposed individuals taking charge of vehicles or machinery should be warned of the hazards. The sedative effect of tricyclic antidepressants is NOT delayed. A tricyclic antidepressant used in the treatment of endogenous depression and has been given as an antipsychotic.

SYNONYMS

C23-H29-N3-O.2HCl, "4-(3-(5H-dibenz[b, f]azepin-5-yl)propyl)-1-piperazi", "4-(3-(5H-dibenz[b, f]azepin-5-yl)propyl)-1-piperazi", "neethanol dihydrochloride", 5-(gamma-(beta-hydroxyethyl)piperazino)propyl)-5H-d, 5-(gamma-(beta-hydroxyethyl)piperazino)propyl)-5H-d, "ibenzo[b, f]azepine HCl", N-[3-[4-(2-hydroxyethyl)piperazino]propyl]iminosti, N-[3-[4-(2-hydroxyethyl)piperazino]propyl]iminosti, "lbene hydrochloride", "4-[3-(5H-dibenzo[b, f]azepin-5-yl)propyl-1-(2-hydro", "4-[3-(5H-dibenzo[b, f]azepin-5-yl)propyl-1-(2-hydro", "xyethyl)piperazine HCl", "opipramol dihydrochloride", Dinsidon, Ensison, G-33040, Insidon, Insidone, "Insidon Dihydrochloride", Nisidana, Pramolan, "tricyclic antidepressant"

Section 2 - HAZARDS IDENTIFICATION

CANADIAN WHMIS SYMBOLS



EMERGENCY OVERVIEW

RISK

Harmful if swallowed.

Very toxic to aquatic organisms, may cause long-term adverse effects in the aquatic environment.

POTENTIAL HEALTH EFFECTS

ACUTE HEALTH EFFECTS

SWALLOWED

■ Accidental ingestion of the material may be harmful; animal experiments indicate that ingestion of less than 150 gram may be fatal or may produce serious damage to the health of the individual.

■ Antipsychotics (also known as neuroleptics) are a group of psychoactive drugs commonly but not exclusively used to treat psychosis, which is typified by schizophrenia. Both first generation drugs (typical antipsychotics) and second generation drugs (atypical antipsychotics) tend to block receptors in the brain's dopamine pathways, but antipsychotic drugs encompass a wide range of receptor targets. A number of side effects have been observed in relation to specific medications, including weight gain, agranulocytosis (a potentially dangerous reduction in the number of white blood cells in the body), tardive dyskinesia (involving involuntary, repetitive movements), tardive akathisia (characterised by unpleasant sensations of "inner" restlessness that manifests itself with an inability to sit still or remain motionless), tardive psychoses and tardive dysphrenia (worsening of psychiatric symptoms).

Detrimental effects on short term memory, which affect the way one figures and calculates (although this also may be purely subjective), may also be observed on high enough dosages.

All antipsychotic drugs tend to block D2 receptors in the dopamine pathways of the brain. This means that dopamine released in these pathways has less effect. Excess release of dopamine in the mesolimbic pathway has been linked to psychotic experiences. It is the blockade of dopamine receptors in this pathway that is thought to control psychotic experiences. Antipsychotic agents do not induce psychological addiction.

A dopamine antagonist is a drug which blocks dopamine receptors (dopaminergics) by receptor antagonism. They are used, typically as antipsychotics, antiemetics and antidepressants. As peripheral and central dopaminergic receptors are similar, the specificity of action of an antagonist on peripheral or central receptors depends primarily on its pharmacokinetic features. If the drug does not cross the blood-brain barrier to a substantial degree, the peripheral effects will prevail (dopamine antagonists of this type are known as "prokinetic" agents); the opposite is true in the case of good penetration in the brain (the antipsychotics or neuroleptics).

The central effects of antipsychotics prevail over their peripheral effects which, nevertheless, remain present.

Psychoses, schizophrenia in particular, are very complex diseases involving negative symptoms (poverty of speech and expression, indifference, carelessness etc.) and productive symptoms (hallucinations, delusion, unsuited behavior, aggressiveness). Antipsychotics improve most of these symptoms, (especially the productive ones).

In animal experiments, antipsychotics agents elicit:

- sedation, reduced motility
- in high doses, catalepsy, i.e. maintenance of unusual positions given to animals by the experimenter
- inhibition of conditioned reflexes with maintenance of primary reflexes
- inhibition of agitation, stereotypes, and vomiting induced by apomorphine or amphetamine.

In human beings, the effects of antipsychotics are different in healthy subjects compared to patients with psychosis:

In healthy subjects they elicit

- drowsiness, indifference, and several adverse effects of the same type as those which are described further.

In psychotic patients, they have three principal effects:

- sedation which results in drowsiness, diminution of vigilance, agitation and excitement
- antideliriant and anti-hallucinogenic effects: decrease of delusion and hallucinations
- anti-autistic effect: patients become more communicative and have a better contact with reality

Antipsychotics have many adverse effects including.

- Sedation, drowsiness.
- Acute dyskinesia which occurs in first hours or first days after the initiation of the treatment by a neuroleptic. Acute dyskinesia is characterised by intermittent muscular spasms, affecting especially face and neck: torticollis, trismus, tongue protrusion, oculogyric attack, opisthotonos. These symptoms, linked to inhibition of D2 dopaminergic receptors of the striatum, are distressing but may be controlled by anticholinergic antiparkinsonian drugs such as trihexyphenidyl. The frequency of acute dyskinesias is lower with atypical neuroleptics like clozapine, olanzapine, risperidone than with conventional neuroleptics.
- Tardive dyskinesia, or lingual-facial-buccal dyskinesia, which occurs after a long treatment with high doses of antipsychotics. Sufferers may show repetitive, involuntary, purposeless movements often of the lips, face, legs, or torso. It is believed that there is a greater risk of developing tardive dyskinesia with the older, typical antipsychotic drugs, although the newer antipsychotics are now also known to cause this disorder. The development of this syndrome appears to be related to the duration of treatment and the total cumulative dose of antipsychotic drugs administered; the syndrome can, however, develop after relatively brief treatment periods at low doses. These abnormal movements persist a long time after the discontinuation of neuroleptic agents, discontinuation which can worsen them. They are not improved by anticholinergic drugs such as trihexyphenidyl.
- Pseudo-parkinsonism with akinesia (slowness of movements), rest and postural tremor, rigidity, hypertonicity. The incidence of these effects is less frequent with atypical antipsychotics.
- Akathisia or impossibility of remaining motionless.
- Rare but severe hyperthermia accompanied by muscular rigidity, called neuroleptic malignant syndrome whose mechanisms are complex.
- Decrease of seizure threshold, for example with clozapine.
- Confusional syndrome: the antimuscarinic effect of most of antipsychotics contributes to appearance of confusional states.
- Passivity and perhaps a certain depressive state.

Digestive

- Mouth dryness
- Hypersalivation, with clozapine for example
- Constipation, often linked to antimuscarinic effects.

Cardiovascular

- Postural hypotension
- Electrocardiographic disorders. A lengthening of QT space was observed during the use of neuroleptics such as droperidol which now is not available in many countries and sultopride by injectable route in the treatment of agitation
- possible implication of neuroleptics in sudden deaths has been evoked.

Endocrine

- Hyperprolactinaemia at the origin of galactorrhea, gynaecomastia, amenorrhea, decreased libido, erection and ejaculation disorders
- weight gain, in particular with atypical neuroleptics such as olanzapine.

Neuroleptics such as clozapine and olanzapine have been suspected to increase the risk of diabetes.

Allergic reactions

- Photosensitisation
- Blood disorders: thrombocytopenia, agranulocytosis particularly with clozapine.

Teratogenesis: The old neuroleptic agents such as chlorpromazine are not teratogenic.

- Antipsychotics, particularly atypicals, appear to cause diabetes mellitus and fatal diabetic ketoacidosis, especially (in US studies) in African Americans.
- Antipsychotics may cause pancreatitis
- The atypical antipsychotics (especially olanzapine) seem to cause weight gain more commonly than the typical antipsychotics. The well-documented metabolic side effects associated with weight gain include diabetes, which can be life-threatening.
- Clozapine also has a risk of inducing agranulocytosis, a potentially dangerous reduction in the number of white blood cells in the body.
- A potentially serious side effect of many antipsychotics is that they tend to lower an individual's seizure threshold. Another antipsychotic side effect is deterioration of teeth due to a lack of saliva.
- Another serious and potentially fatal side effect is sometimes referred to as Neuroleptic Malignant Syndrome, in which the drugs appear to cause the temperature regulation centers to fail, resulting in a medical emergency, as the patient's temperature suddenly increases to dangerous levels.
- Other clinical manifestations include hyperpyrexia, muscle rigidity, altered mental state, and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis and cardiac dysrhythmia. Additional signs may include elevated creatine phosphokinase, myoglobinuria (rhabdomyolysis) and acute renal failure.
- Other side-effects of drug therapy may include a disruption to the body's ability to reduce body core temperature and dysphagia (oesophageal dysmotility and aspiration - aspiration pneumonia is a common cause of morbidity or mortality in elderly patients especially those with advanced Alzheimer's dementia).

Dopamine has an emetic effect and inhibits digestive motility; its antagonists have antiemetic and digestive motility stimulant effects. Dopaminergic receptors in the chemoreceptor trigger zone responsible for vomiting are accessible to dopaminergic antagonists which do not cross the blood-brain barrier. Drugs stimulating gastrointestinal motility are called prokinetic agents and are used specially in treating gastroesophageal reflux.

■ Side effects of tricyclic antidepressants include dry mouth, sour or metallic taste, constipation, retention of urine, blurred vision and changes in focusing, palpitations, and fast heart beat. Gastrointestinal disturbances (including nausea and vomiting), drowsiness, tremor, low blood pressure when standing, dizziness, sweating, weakness and fatigue, inco-ordination, epilepsy-like seizures, and speech difficulties may occur. Allergic skin reactions and sensitivity to light have been reported, as well as jaundice and blood disorders. Effects on the heart muscle may produce conduction defects and irregularities in heart beat. Endocrine effects may produce changes in sexdrive, impotence, enlarged breasts and copious milk production. Changes in blood sugar levels and reduced levels of antidiuretic hormone may also occur. Overdose may produce excitement and restlessness with dry mouth, dilated pupils, increased heart rate, retention of urine and absence of bowel sounds. More severe poisoning may produce convulsions and muscle spasms, low blood pressure and depression of breathing and the heart. There may be life-threatening heartbeat irregularities that occurs some days after apparent recovery.

■ Patients of any age with Major Depressive Disorder may experience worsening of their depression and/or the emergence of suicidal ideation and behaviour (suicidality), whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Patients should be closely monitored, especially at the beginning of therapy or when the dose is changed, until such improvement occurs.

There has been a long-standing concern that some antidepressants may have a role in the emergence of suicidality in some patients. The possible risk of increased suicidality in patients applies to all classes of antidepressant medicines, as available data are not adequate to exclude this risk for any antidepressant. Therefore, consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients whose depression is persistently worse or whose emergent suicidality is severe, abrupt in onset, or was not part of the patient's presenting symptoms. Generally, when stopping an antidepressant, doses should be tapered rather than stopped abruptly.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility (aggressiveness), impulsivity, akathisia (psychomotor restlessness), hypomania and mania, have been reported in adult and paediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and non-psychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication, in patients for whom such symptoms are severe, abrupt in onset, or were not part of the patient's presenting symptoms.

Because of the possibility of co-morbidity between major depressive disorder and other psychiatric and non-psychiatric disorders, the same precautions observed when treating patients with major depressive disorder should be observed when treating patients with other psychiatric and non-psychiatric disorders.

Mania and Bipolar Disorder: A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with any antidepressant alone may increase the likelihood of a mixed-manic episode in patients at risk for bipolar disorder. Prior to initiating treatment with an antidepressant, patients should be adequately screened to determine if they are at risk for bipolar disorder.

EYE

■ Although the material is not thought to be an irritant, direct contact with the eye may cause transient discomfort characterized by tearing or conjunctival redness (as with windburn). Slight abrasive damage may also result. The material may produce foreign body irritation in certain individuals.

SKIN

■ The material is not thought to be a skin irritant (as classified using animal models). Abrasive damage however, may result from prolonged exposures. Good hygiene practice requires that exposure be kept to a minimum and that suitable gloves be used in an occupational setting.

■ Skin contact with the material may damage the health of the individual; systemic effects may result following absorption.

■ Open cuts, abraded or irritated skin should not be exposed to this material.

■ Entry into the blood-stream, through, for example, cuts, abrasions or lesions, may produce systemic injury with harmful effects. Examine the skin prior to the use of the material and ensure that any external damage is suitably protected.

INHALED

■ The material is not thought to produce either adverse health effects or irritation of the respiratory tract following inhalation (as classified using animal models). Nevertheless, adverse effects have been produced following exposure of animals by at least one other route and good hygiene practice requires that exposure be kept to a minimum and that suitable control measures be used in an occupational setting.

■ Persons with impaired respiratory function, airway diseases and conditions such as emphysema or chronic bronchitis, may incur further disability if excessive concentrations of particulate are inhaled.

CHRONIC HEALTH EFFECTS

■ There has been some concern that this material can cause cancer or mutations but there is not enough data to make an assessment.

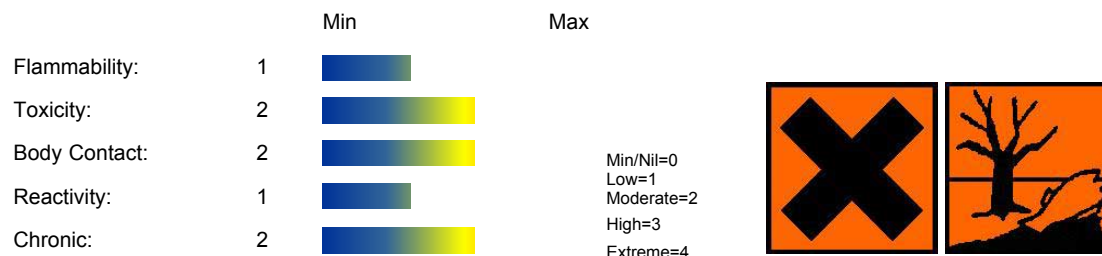
An increase in the incidence of mammary adenocarcinomas is a common finding for D2 antagonists which increase prolactin secretion when administered to rats. An increase in the incidence of pancreatic islet cell tumours has been observed for some other D2 antagonists. The physiological differences between rats and humans with regard to prolactin make the clinical significance of these findings unclear.

Antipsychotic drugs have been shown to chronically elevate prolactin levels in rodents. Increases in mammary neoplasms have

been found in rodents after chronic administration of antipsychotic drugs and are considered to be prolactin-mediated. Increased prolactin levels in serum are a secondary consequence of chronic dopamine antagonism of pituitary lactotrophs. The relevance of the increased incidence of prolactin-mediated mammary gland tumours in rats, to human risk, is unknown. Reproductive and developmental toxicity may also result from exposure to dopamine antagonists; these may result from elevation of serum prolactin. Effects may include prolonged oestrus, pre-implantation loss and alterations to the length of the gestational cycle. Long term exposure to high dust concentrations may cause changes in lung function i.e. pneumoconiosis; caused by particles less than 0.5 micron penetrating and remaining in the lung. Prime symptom is breathlessness; lung shadows show on X-ray.

Section 3 - COMPOSITION / INFORMATION ON INGREDIENTS

HAZARD RATINGS



NAME	CAS RN	%
opipramol hydrochloride	909-39-7	>98

Section 4 - FIRST AID MEASURES

SWALLOWED

- IF SWALLOWED, REFER FOR MEDICAL ATTENTION, WHERE POSSIBLE, WITHOUT DELAY.
- Where Medical attention is not immediately available or where the patient is more than 15 minutes from a hospital or unless instructed otherwise:
- For advice, contact a Poisons Information Center or a doctor.
- Urgent hospital treatment is likely to be needed.
- If conscious, give water to drink.
- INDUCE vomiting with fingers down the back of the throat, ONLY IF CONSCIOUS. Lean patient forward or place on left side (head-down position, if possible) to maintain open airway and prevent aspiration.

NOTE: Wear a protective glove when inducing vomiting by mechanical means.

- In the mean time, qualified first-aid personnel should treat the patient following observation and employing supportive measures as indicated by the patient's condition.
- If the services of a medical officer or medical doctor are readily available, the patient should be placed in his/her care and a copy of the MSDS should be provided. Further action will be the responsibility of the medical specialist.
- If medical attention is not available on the worksite or surroundings send the patient to a hospital together with a copy of the MSDS.

EYE

- If this product comes in contact with the eyes:
- Wash out immediately with fresh running water.
- Ensure complete irrigation of the eye by keeping eyelids apart and away from eye and moving the eyelids by occasionally lifting the upper and lower lids.
- If pain persists or recurs seek medical attention.
- Removal of contact lenses after an eye injury should only be undertaken by skilled personnel.

SKIN

- If skin contact occurs:
- Immediately remove all contaminated clothing, including footwear
- Flush skin and hair with running water (and soap if available).
- Seek medical attention in event of irritation.

INHALED

-
- If dust is inhaled, remove from contaminated area.
- Encourage patient to blow nose to ensure clear passage of breathing.
- If irritation or discomfort persists seek medical attention.

NOTES TO PHYSICIAN

- The management of NMS (Neuroleptic Malignant syndrome) should include:
- immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy;
- intensive symptomatic treatment and medical monitoring and
- treatment of any concomitant serious medical problems for which specific treatments are available.
- There is no general agreement about specific pharmacological regimes for NMS.

For tricyclic antidepressant poisonings: The stomach should be emptied by aspiration and lavage. Activated charcoal as an adjunct to gastric lavage may also be used. Supportive therapy alone may then suffice for patients who are not severely poisoned. In particular monitor for cardiac arrhythmias and institute anti-arrhythmic measures necessary (digoxin and physostigmine salicylate are NOT recommended). Convulsions may be managed by intravenous diazepam. Physostigmine (not neostigmine) may also be used to control convulsions but caution must be exercised. Barbiturates are generally not advocated since they exacerbate respiratory depression. Some workers claim promising results with charcoal hemoperfusion in severely poisoned patients. MARTINDALE: The Extra Pharmacopoeia, 28th Edition.

Readily absorbed from the gastrointestinal tract. Slow gastrointestinal transit time and absorption may be delayed especially in overdose.

Section 5 - FIRE FIGHTING MEASURES

Vapour Pressure (mmHG):	Negligible
Upper Explosive Limit (%):	Not available
Specific Gravity (water=1):	Not available
Lower Explosive Limit (%):	Not available

EXTINGUISHING MEDIA

■

- Water spray or fog.
- Foam.
- Dry chemical powder.
- BCF (where regulations permit).
- Carbon dioxide.

FIRE FIGHTING

■

- Alert Emergency Responders and tell them location and nature of hazard.
- Wear breathing apparatus plus protective gloves.
- Prevent, by any means available, spillage from entering drains or water course.
- Use water delivered as a fine spray to control fire and cool adjacent area.
- DO NOT approach containers suspected to be hot.
- Cool fire exposed containers with water spray from a protected location.
- If safe to do so, remove containers from path of fire.
- Equipment should be thoroughly decontaminated after use.

GENERAL FIRE HAZARDS/HAZARDOUS COMBUSTIBLE PRODUCTS

■

- Combustible solid which burns but propagates flame with difficulty.
- Avoid generating dust, particularly clouds of dust in a confined or unventilated space as dusts may form an explosive mixture with air, and any source of ignition, i.e. flame or spark, will cause fire or explosion. Dust clouds generated by the fine grinding of the solid are a particular hazard; accumulations of fine dust may burn rapidly and fiercely if ignited.
- Dry dust can be charged electrostatically by turbulence, pneumatic transport, pouring, in exhaust ducts and during transport.
- Build-up of electrostatic charge may be prevented by bonding and grounding.
- Powder handling equipment such as dust collectors, dryers and mills may require additional protection measures such as explosion venting.

Combustion products include: carbon monoxide (CO), carbon dioxide (CO₂), hydrogen chloride, phosgene, nitrogen oxides (NO_x), other pyrolysis products typical of burning organic material.

FIRE INCOMPATIBILITY

■ Avoid contamination with oxidizing agents i.e. nitrates, oxidizing acids, chlorine bleaches, pool chlorine etc. as ignition may result.

PERSONAL PROTECTION

Glasses:

Chemical goggles.

Gloves:

Respirator:

Particulate

Section 6 - ACCIDENTAL RELEASE MEASURES

MINOR SPILLS

■ Environmental hazard - contain spillage.

- Clean up waste regularly and abnormal spills immediately.
- Avoid breathing dust and contact with skin and eyes.
- Wear protective clothing, gloves, safety glasses and dust respirator.
- Use dry clean up procedures and avoid generating dust.
- Vacuum up or sweep up. NOTE: Vacuum cleaner must be fitted with an exhaust micro filter (HEPA type) (consider explosion-proof machines designed to be grounded during storage and use).
- Dampen with water to prevent dusting before sweeping.
- Place in suitable containers for disposal.

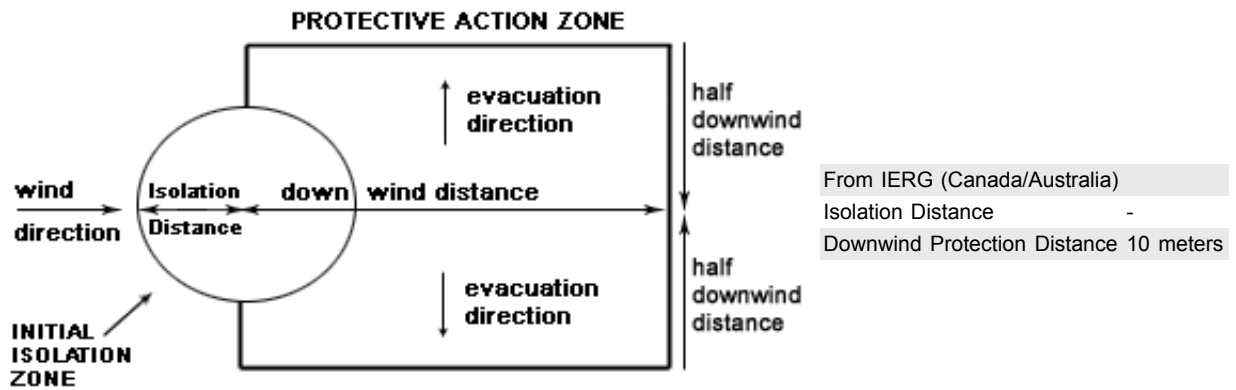
MAJOR SPILLS

■ Environmental hazard - contain spillage.

Moderate hazard.

- CAUTION: Advise personnel in area.
- Alert Emergency Responders and tell them location and nature of hazard.
- Control personal contact by wearing protective clothing.
- Prevent, by any means available, spillage from entering drains or water courses.
- Recover product wherever possible.
- IF DRY: Use dry clean up procedures and avoid generating dust. Collect residues and place in sealed plastic bags or other containers for disposal. IF WET: Vacuum/shovel up and place in labelled containers for disposal.
- ALWAYS: Wash area down with large amounts of water and prevent runoff into drains.
- If contamination of drains or waterways occurs, advise emergency services.

PROTECTIVE ACTIONS FOR SPILL



FOOTNOTES

1 PROTECTIVE ACTION ZONE is defined as the area in which people are at risk of harmful exposure. This zone assumes that random changes in wind direction confines the vapour plume to an area within 30 degrees on either side of the predominant wind direction, resulting in a crosswind protective action distance equal to the downwind protective action distance.

2 PROTECTIVE ACTIONS should be initiated to the extent possible, beginning with those closest to the spill and working away from the site in the downwind direction. Within the protective action zone a level of vapour concentration may exist resulting in nearly all unprotected persons becoming incapacitated and unable to take protective action and/or incurring serious or irreversible health effects.

3 INITIAL ISOLATION ZONE is determined as an area, including upwind of the incident, within which a high probability of localised wind reversal may expose nearly all persons without appropriate protection to life-threatening concentrations of the material.

4 SMALL SPILLS involve a leaking package of 200 litres (55 US gallons) or less, such as a drum (jerrican or box with inner containers). Larger packages leaking less than 200 litres and compressed gas leaking from a small cylinder are also considered "small spills". LARGE SPILLS involve many small leaking packages or a leaking package of greater than 200 litres, such as a cargo tank, portable tank or a "one-tonne" compressed gas cylinder.

5 Guide 171 is taken from the US DOT emergency response guide book.

6 IERG information is derived from CANUTEC - Transport Canada.

ACUTE EXPOSURE GUIDELINE LEVELS (AEGL) (in ppm)

AEGL 1: The airborne concentration of a substance above which it is predicted that the general population, including susceptible individuals, could experience notable discomfort, irritation, or certain asymptomatic nonsensory effects. However, the effects are not disabling and are transient and reversible upon cessation of exposure.

AEGL 2: The airborne concentration of a substance above which it is predicted that the general population, including susceptible individuals, could experience irreversible or other serious, long-lasting adverse health effects or an impaired ability to escape.

AEGL 3: The airborne concentration of a substance above which it is predicted that the general population, including susceptible individuals, could experience life-threatening health effects or death.

Section 7 - HANDLING AND STORAGE

PROCEDURE FOR HANDLING

-
- Avoid all personal contact, including inhalation.
- Wear protective clothing when risk of exposure occurs.
- Use in a well-ventilated area.
- Prevent concentration in hollows and sumps.
- DO NOT enter confined spaces until atmosphere has been checked.
- DO NOT allow material to contact humans, exposed food or food utensils.
- Avoid contact with incompatible materials.
- When handling, DO NOT eat, drink or smoke.
- Keep containers securely sealed when not in use.
- Avoid physical damage to containers.
- Always wash hands with soap and water after handling.
- Work clothes should be laundered separately.
- Launder contaminated clothing before re-use.
- Use good occupational work practice.
- Observe manufacturer's storing and handling recommendations.
- Atmosphere should be regularly checked against established exposure standards to ensure safe working conditions are maintained.

Empty containers may contain residual dust which has the potential to accumulate following settling. Such dusts may explode in the presence of an appropriate ignition source.

- Do NOT cut, drill, grind or weld such containers
- In addition ensure such activity is not performed near full, partially empty or empty containers without appropriate workplace safety authorisation or permit.

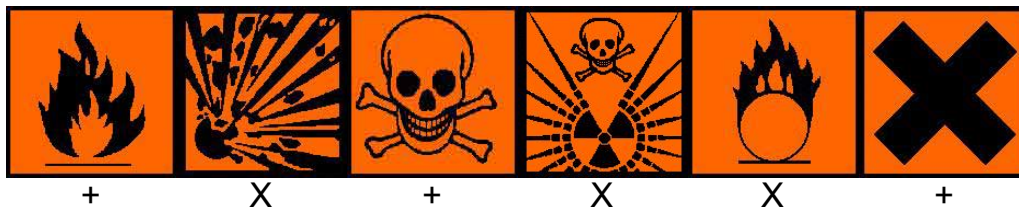
RECOMMENDED STORAGE METHODS

- Glass container.
- Polyethylene or polypropylene container.
- Check all containers are clearly labelled and free from leaks.

STORAGE REQUIREMENTS

- Observe manufacturer's storing and handling recommendations.

SAFE STORAGE WITH OTHER CLASSIFIED CHEMICALS



X: Must not be stored together

O: May be stored together with specific preventions

+: May be stored together

Section 8 - EXPOSURE CONTROLS / PERSONAL PROTECTION

EXPOSURE CONTROLS

The following materials had no OELs on our records

- opipramol hydrochloride: CAS:909-39-7

MATERIAL DATA

OPIPRAMOL HYDROCHLORIDE:

- It is the goal of the ACGIH (and other Agencies) to recommend TLVs (or their equivalent) for all substances for which there is evidence of health effects at airborne concentrations encountered in the workplace.

At this time no TLV has been established, even though this material may produce adverse health effects (as evidenced in animal experiments or clinical experience). Airborne concentrations must be maintained as low as is practically possible and occupational exposure must be kept to a minimum.

NOTE: The ACGIH occupational exposure standard for Particles Not Otherwise Specified (P.N.O.S) does NOT apply.

Airborne particulate or vapor must be kept to levels as low as is practicably achievable given access to modern engineering controls and monitoring hardware. Biologically active compounds may produce idiosyncratic effects which are entirely unpredictable on the basis of literature searches and prior clinical experience (both recent and past).

PERSONAL PROTECTION



Consult your EHS staff for recommendations

EYE

- When handling very small quantities of the material eye protection may not be required.

For laboratory, larger scale or bulk handling or where regular exposure in an occupational setting occurs:

- Chemical goggles
- Face shield. Full face shield may be required for supplementary but never for primary protection of eyes
- Contact lenses may pose a special hazard; soft contact lenses may absorb and concentrate irritants. A written policy document, describing the wearing of lens or restrictions on use, should be created for each workplace or task. This should include a review of lens absorption and adsorption for the class of chemicals in use and an account of injury experience. Medical and first-aid personnel should be trained in their removal and suitable equipment should be readily available. In the event of chemical exposure, begin eye irrigation immediately and remove contact lens as soon as practicable. Lens should be removed at the first signs of eye redness or irritation - lens should be removed in a clean environment only after workers have washed hands thoroughly. [CDC NIOSH Current Intelligence Bulletin 59]

HANDS/FEET

- Suitability and durability of glove type is dependent on usage. Important factors in the selection of gloves include: such as:

- frequency and duration of contact,
- chemical resistance of glove material,
- glove thickness and
- dexterity

Select gloves tested to a relevant standard (e.g. Europe EN 374, US F739).

- When prolonged or frequently repeated contact may occur, a glove with a protection class of 5 or higher (breakthrough time greater than 240 minutes according to EN 374) is recommended.
- When only brief contact is expected, a glove with a protection class of 3 or higher (breakthrough time greater than 60 minutes according to EN 374) is recommended.
- Contaminated gloves should be replaced.

Gloves must only be worn on clean hands. After using gloves, hands should be washed and dried thoroughly. Application of a non-perfumed moisturiser is recommended.

- Rubber gloves (nitrile or low-protein, powder-free latex). Employees allergic to latex gloves should use nitrile gloves in preference.
- Double gloving should be considered.
- PVC gloves.
- Protective shoe covers.
- Head covering.

Experience indicates that the following polymers are suitable as glove materials for protection against undissolved, dry solids,

where abrasive particles are not present.

- polychloroprene
- nitrile rubber
- butyl rubber
- fluorocautchouc
- polyvinyl chloride

Gloves should be examined for wear and/ or degradation constantly.

OTHER

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- For quantities up to 500 grams a laboratory coat may be suitable.
- For quantities up to 1 kilogram a disposable laboratory coat or coverall of low permeability is recommended. Coveralls should be buttoned at collar and cuffs.
- For quantities over 1 kilogram and manufacturing operations, wear disposable coverall of low permeability and disposable shoe covers.
- For manufacturing operations, air-supplied full body suits may be required for the provision of advanced respiratory protection.
- Eye wash unit.
- Ensure there is ready access to an emergency shower.
- For Emergencies: Vinyl suit
-
- Respirators may be necessary when engineering and administrative controls do not adequately prevent exposures.
- The decision to use respiratory protection should be based on professional judgment that takes into account toxicity information, exposure measurement data, and frequency and likelihood of the worker's exposure - ensure users are not subject to high thermal loads which may result in heat stress or distress due to personal protective equipment (powered, positive flow, full face apparatus may be an option).
- Published occupational exposure limits, where they exist, will assist in determining the adequacy of the selected respiratory . These may be government mandated or vendor recommended.
- Certified respirators will be useful for protecting workers from inhalation of particulates when properly selected and fit tested as part of a complete respiratory protection program.
- Use approved positive flow mask if significant quantities of dust becomes airborne.
- Try to avoid creating dust conditions.

RESPIRATOR

■

Protection Factor	Half-Face Respirator	Full-Face Respirator	Powered Air Respirator
10 x PEL	P1	-	PAPR-P1
	Air-line*	-	-
50 x PEL	Air-line**	P2	PAPR-P2
100 x PEL	-	P3	-
		Air-line*	-
100+ x PEL	-	Air-line**	PAPR-P3

* - Negative pressure demand ** - Continuous flow

Explanation of Respirator Codes:

Class 1 low to medium absorption capacity filters.

Class 2 medium absorption capacity filters.

Class 3 high absorption capacity filters.

PAPR Powered Air Purifying Respirator (positive pressure) cartridge.

Type A for use against certain organic gases and vapors.

Type AX for use against low boiling point organic compounds (less than 65°C).

Type B for use against certain inorganic gases and other acid gases and vapors.

Type E for use against sulfur dioxide and other acid gases and vapors.

Type K for use against ammonia and organic ammonia derivatives

Class P1 intended for use against mechanically generated particulates of sizes most commonly encountered in industry, e.g. asbestos, silica.

Class P2 intended for use against both mechanically and thermally generated particulates, e.g. metal fume.

Class P3 intended for use against all particulates containing highly toxic materials, e.g. beryllium.

The local concentration of material, quantity and conditions of use determine the type of personal protective equipment required.

Use appropriate NIOSH-certified respirator based on informed professional judgement. In conditions where no reasonable estimate of exposure can be made, assume the exposure is in a concentration IDLH and use NIOSH-certified full face pressure demand SCBA with a minimum service life of 30 minutes, or a combination full facepiece pressure demand SAR with auxiliary self-contained air supply. Respirators provided only for escape from IDLH atmospheres shall be NIOSH-certified for escape from the atmosphere in which they will be used.

ENGINEERING CONTROLS

■ Enclosed local exhaust ventilation is required at points of dust, fume or vapor generation.

HEPA terminated local exhaust ventilation should be considered at point of generation of dust, fumes or vapors.

Barrier protection or laminar flow cabinets should be considered for laboratory scale handling.

The need for respiratory protection should also be assessed where incidental or accidental exposure is anticipated: Dependent on levels of contamination, PAPR, full face air purifying devices with P2 or P3 filters or air supplied respirators should be evaluated.

Fume-hoods and other open-face containment devices are acceptable when face velocities of at least 1 m/s (200 feet/minute) are achieved. Partitions, barriers, and other partial containment technologies are required to prevent migration of the material to uncontrolled areas. For non-routine emergencies maximum local and general exhaust are necessary. Air contaminants generated in the workplace possess varying "escape" velocities which, in turn, determine the "capture velocities" of fresh circulating air required to effectively remove the contaminant.

Type of Contaminant:	Air Speed:
solvent, vapors, etc. evaporating from tank (in still air)	0.25-0.5 m/s (50-100 f/min.)
aerosols, fumes from pouring operations, intermittent container filling, low speed conveyer transfers (released at low velocity into zone of active generation)	0.5-1 m/s (100-200 f/min.)
direct spray, drum filling, conveyer loading, crusher dusts, gas	1-2.5 m/s (200-500 f/min.)

discharge (active generation into zone of rapid air motion) 1-2.5 m/s (200-500 f/min.)

Within each range the appropriate value depends on:

Lower end of the range	Upper end of the range
1: Room air currents minimal or favourable to capture	1: Disturbing room air currents
2: Contaminants of low toxicity or of nuisance value only.	2: Contaminants of high toxicity
3: Intermittent, low production.	3: High production, heavy use
4: Large hood or large air mass in motion	4: Small hood-local control only

Simple theory shows that air velocity falls rapidly with distance away from the opening of a simple extraction pipe. Velocity generally decreases with the square of distance from the extraction point (in simple cases). Therefore the air speed at the extraction point should be adjusted, accordingly, after reference to distance from the contaminating source. The air velocity at the extraction fan, for example, should be a minimum of 1-2.5 m/s (200-500 f/min.) for extraction of gases discharged 2 meters distant from the extraction point. Other mechanical considerations, producing performance deficits within the extraction apparatus, make it essential that theoretical air velocities are multiplied by factors of 10 or more when extraction systems are installed or used.

Section 9 - PHYSICAL AND CHEMICAL PROPERTIES

PHYSICAL PROPERTIES

Solid.

Mixes with water.

State	Divided solid	Molecular Weight	436.47
Melting Range (°F)	410 (decomposes)	Viscosity	Not Applicable
Boiling Range (°F)	Not available	Solubility in water (g/L)	Miscible
Flash Point (°F)	Not available	pH (1% solution)	Not available
Decomposition Temp (°F)	410	pH (as supplied)	Not applicable
Autoignition Temp (°F)	Not available	Vapour Pressure (mmHG)	Negligible
Upper Explosive Limit (%)	Not available	Specific Gravity (water=1)	Not available
Lower Explosive Limit (%)	Not available	Relative Vapor Density (air=1)	Not Applicable
Volatile Component (%vol)	Negligible	Evaporation Rate	Not available

APPEARANCE

Light yellow crystalline powder; mixes with water, alcohol. May develop a reddish tinge on prolonged exposure to light.

Section 10 - CHEMICAL STABILITY

CONDITIONS CONTRIBUTING TO INSTABILITY

-
- Presence of incompatible materials.
- Product is considered stable.
- Hazardous polymerization will not occur.

STORAGE INCOMPATIBILITY

- Avoid reaction with oxidizing agents.

For incompatible materials - refer to Section 7 - Handling and Storage.

Section 11 - TOXICOLOGICAL INFORMATION

opipramol hydrochloride

TOXICITY AND IRRITATION

- unless otherwise specified data extracted from RTECS - Register of Toxic Effects of Chemical Substances.

TOXICITY	IRRITATION
Oral (rat) LD50: 900 mg/kg	Nil Reported
Intraperitoneal (rat) LD50: 95 mg/kg	
Subcutaneous (rat) LD50: 497 mg/kg	
Intravenous (rat) LD50: 32 mg/kg	
Oral (mouse) LD50: 443 mg/kg	
Intraperitoneal (mouse) LD50: 120 mg/kg	
Subcutaneous (mouse) LD50: 315 mg/kg	
Intravenous (mouse) LD50: 45 mg/kg	
Oral (human) TDLo: 36 mg/kg/25d - C	
Somnolence recorded.	

Section 12 - ECOLOGICAL INFORMATION

Refer to data for ingredients, which follows:

OPIPRAMOL HYDROCHLORIDE:

- Very toxic to aquatic organisms, may cause long-term adverse effects in the aquatic environment.
 - Do NOT allow product to come in contact with surface waters or to intertidal areas below the mean high water mark. Do not contaminate water when cleaning equipment or disposing of equipment wash-waters.
- Wastes resulting from use of the product must be disposed of on site or at approved waste sites.
- DO NOT discharge into sewer or waterways.

Section 13 - DISPOSAL CONSIDERATIONS

Disposal Instructions

All waste must be handled in accordance with local, state and federal regulations.

! Puncture containers to prevent re-use and bury at an authorized landfill.

Legislation addressing waste disposal requirements may differ by country, state and/ or territory. Each user must refer to laws operating in their area. In some areas, certain wastes must be tracked.

A Hierarchy of Controls seems to be common - the user should investigate:

- Reduction
- Reuse
- Recycling
- Disposal (if all else fails)

This material may be recycled if unused, or if it has not been contaminated so as to make it unsuitable for its intended use. Shelf life considerations should also be applied in making decisions of this type. Note that properties of a material may change in use, and recycling or reuse may not always be appropriate.

DO NOT allow wash water from cleaning equipment to enter drains. Collect all wash water for treatment before disposal.

- Recycle wherever possible.
- Consult manufacturer for recycling options or consult Waste Management Authority for disposal if no suitable treatment or disposal facility can be identified.
- Dispose of by: Burial in a licensed land-fill or Incineration in a licensed apparatus (after admixture with suitable combustible material)
- Decontaminate empty containers. Observe all label safeguards until containers are cleaned and destroyed.

Section 14 - TRANSPORTATION INFORMATION



DOT:

Symbols:	G	Hazard class or Division:	9
Identification Numbers:	UN3077	PG:	III
Label Codes:	9	Special provisions:	8, 146, 335, B54, IB8, IP3, N20, T1, TP33
Packaging: Exceptions:	155	Packaging: Non-bulk:	213
Packaging: Exceptions:	155	Quantity limitations: Passenger aircraft/rail:	No limit
Quantity Limitations: Cargo aircraft only:	No limit	Vessel stowage: Location:	A
Vessel stowage: Other:	None		

Hazardous materials descriptions and proper shipping names:

Environmentally hazardous substance, solid, n.o.s

Air Transport IATA:

ICAO/IATA Class:	9	ICAO/IATA Subrisk:	III
UN/ID Number:	3077	Packing Group:	III
Special provisions:	A97		

Shipping Name: ENVIRONMENTALLY HAZARDOUS SUBSTANCE, SOLID, N.O.S. *(CONTAINS OPIPRAMOL HYDROCHLORIDE)

Maritime Transport IMDG:

IMDG Class:	9	IMDG Subrisk:	None
UN Number:	3077	Packing Group:	III
EMS Number:	F-A,S-F	Special provisions:	274 909 944

Limited Quantities: 5 kg

Shipping Name: ENVIRONMENTALLY HAZARDOUS SUBSTANCE, SOLID, N.O.S.(contains opipramol hydrochloride)

Section 15 - REGULATORY INFORMATION

No data for pipramol hydrochloride (CAS: , 909-39-7)

Section 16 - OTHER INFORMATION

LIMITED EVIDENCE

- Skin contact may produce health damage*.
- Limited evidence of a carcinogenic effect*.

* (limited evidence).

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■ Classification of the mixture and its individual components has drawn on official and authoritative sources as well as independent review by the Chemwatch Classification committee using available literature references.

A list of reference resources used to assist the committee may be found at:

www.chemwatch.net/references.

■ The (M)SDS is a Hazard Communication tool and should be used to assist in the Risk Assessment. Many factors determine whether the reported Hazards are Risks in the workplace or other settings. Risks may be determined by reference to Exposures Scenarios. Scale of use, frequency of use and current or available engineering controls must be considered.

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Issue Date: Nov-25-2009

Print Date: Apr-22-2010