

the gel form) by the intravenous route, changing to this product for maintenance therapy.

Although the dosage must be individualized to the patient and the disturbance being treated, the initial dose requirements will probably be in the vicinity of 40 to 60 units of corticotropin per day. Ordinarily, where the preparation is to be used continuously, or for prolonged periods, the daily dose should not be over 20 units and usually less. It is preferable to maintain the dosage of ACTH at a level that will avoid undesirable side effects even though this dosage be insufficient to produce complete relief of the clinical disorder under treatment. Minimum dosage levels should be used in all cases of prolonged therapy. The amount required per day governs the frequency of injections; for example, if 60 units are required, the amount is given as two equally divided doses, if less than 40 units is required, the dose is administered as a single daily injection.

It is best to decrease the dosage as quickly as possible after the desired response is obtained. First, the dose is reduced to about three-fourths that needed initially; this is continued for about a week to determine its adequacy. The dose is again reduced step-wise by one-fourth every 5 to 7 days until the lowest maintenance dose is established. After about a week, this dose is administered every other day. If improvement is maintained, then the interval is lengthened to every three days. The general principle is to give the smallest dose in the longest interval. If the dose needed for full relief produces significant side effects it should be reduced and the physician should content himself with less than full suppression of the disease being treated.

CONTRAINDICATIONS

1. Tuberculosis—Active or latent tuberculosis is a definite contraindication for prolonged therapy.
2. Congestive Heart Failure and Hypertension—Corticotropin therapy, through its tendency to induce electrolyte and fluid retention, is undesirable for these conditions.
3. Psychotic and Psychopathic Personalities—Corticotropin therapy may precipitate undesired incidents, and hence persons with psychopathic personalities should usually not receive the drug until further studies have been made.
4. Diabetes Mellitus—Corticotropin therapy may increase the blood sugar levels especially of controlled diabetics or latent diabetics so that glycosuria may result. This may be controlled by increasing the insulin dosage and adjustment of diet, and in most cases discontinuance of the corticotropin brings blood sugar levels and insulin requirements back to pretreatment values.
5. Chronic Nephritis—It is essential that the patient be able to eliminate excess water which tends to be retained on corticotropin therapy, due to sodium retention. The inability of the nephrotic to eliminate excess fluid requires caution.
6. Cushing's syndrome—This disease is due to excessive function of the adrenal cortex or to tumors, and corticotropin therapy is contraindicated.
7. Addison's Disease—Corticotropin therapy is ineffective in the absence of adrenal tissue.
8. Thrombophlebitis—Since ACTH therapy tends to increase the thrombophilic tendency, patients, particularly those confined to bed or chair, should be watched for signs of phlebothrombosis, which should be treated with anticoagulant therapy before and during the ACTH therapy.

INDICATIONS

The following dosage recommendations for this product to be administered subcutaneously or intramuscularly are intended as suggestions for initial therapy, and thereafter the dosage must be adjusted to the individual needs of the patient.

Rheumatoid Arthritis—The initial dose is 60 units once a day; for severe cases, 30 to 40 units every 12 hours. If clinical response is not obtained after several days, increase dose to 80 units every 24 hours. After remission occurs, gradually reduce dose as described under Dosage Considerations.

Acute Rheumatic Fever—In young children 40 units per day as one injection; if acutely ill, 30 units every 12 hours. For older children, 60 units once a day. Full treatment for 4 days, then gradual tapering off and treatment discontinued.

Acute Lupus Erythematosus—The initial dose is 60 units every 24 hours. The patient should be maintained on the effective dose for 2 to 3 weeks at which time the dose should be reduced to the minimum maintenance level. These patients must be carefully observed for edema with cardiac and nephritic involvement. Low sodium diet and increased potassium intake is advisable.