

tenance dose should then be determined for each patient and this will usually range between 0.75 and 1.5 mg. per day. Dosage titration is easily accomplished by decreasing the daily dose by 0.25 mg. or 0.375 mg. every three days or so. The use of a single daily dose may prove effective in certain patients and may be worthy of trial initially. However, if the response is not satisfactory the daily drug requirement should then be given in divided doses.

Because of the spontaneous remissions seen in this disease it may be advisable from time to time to discontinue therapy to evaluate this point, particularly in patients whose daily drug requirements are low. It should be emphasized that this agent is most effective when used in conjunction with other standard measures such as rest, physiotherapy, orthopedic corrections, etc.

Acute Rheumatic Fever—It can be expected to exert the same type and degree of beneficial effects noted with other corticosteroids in the treatment of this disease. Unlike earlier corticosteroids, it has the added advantage that salt and water retention are rarely observed, at least at the lower dosage levels. The true role of these agents in preventing valvular damage has yet to be determined. High doses are usually required to bring this disease under control and initially these may range from 7.5 to 10 mg. daily. As symptoms improve, dosage should be decreased gradually until a satisfactory maintenance level is reached.

Hypersensitivity States—Allergic diseases such as bronchial asthma, angioneurotic edema, allergic dermaloses, allergic purpura, certain drug reactions, transfusion reactions, etc. constitute another group of disorders responsive to corticosteroid therapy. In general a single daily dose will usually provide adequate symptomatic control. Sufficiently high doses should be given initially to provide relief and these may range from 3.0 to 6.0 mg. per day. When long-term therapy is required, the effective minimal dose should be determined for each patient by gradually reducing dosage by 0.25 mg. to 0.375 mg. every second or third day.

For relatively minor conditions such as intractable hay fever or allergic rhinitis, the use of this agent may usually be discontinued after 10 to 14 days. Standard antiallergic therapy should be tried initially with corticosteroid supplementation only if required.

Inflammatory Eye Diseases—Ocular diseases which are known to respond to such therapy include: iritis, iridocyclitis, ureitis, choroiditis and chorioretinitis. In iritis or iridocyclitis topical treatment should be tried before restoring to systemic use. The drug is contraindicated in herpes simplex and herpes keratitis.

Beginning doses range from 3.0 to 6.0 mg. per day. When symptoms are satisfactorily controlled, dosage should be decreased by 0.50 to 0.75 mg. daily until a satisfactory maintenance dose is achieved. In acute or self-limited conditions, corticosteroids should be discontinued at the earliest possible moment.

Skin Disorders—Dermatitis of the atopic, contact, exfoliative, or drug reaction types respond rapidly and favorably, a single daily dose usually providing symptomatic relief. Skin diseases of a more serious impact such as pemphigus vulgaris and mycosis fungoides may also respond to corticosteroid therapy. The skin lesions associated with collagen diseases such as lupus erythematosus, scleroderma, and dermatomyositis do not require treatment but may respond favorably to courses of corticosteroid therapy being given for the underlying disease. Dosage requirements for these various skin disorders should be based on the degree of involvement and severity of the underlying disease. Minor afflictions require therapy for a few days or weeks at most while the more serious ones may demand continuous treatment. In general initial doses range from 3.0 to 6.0 mg. per day with gradual reductions down to a satisfactory maintenance level. Higher daily drug requirements should be given in divided doses.

Dosage recommendations for the treatment of pemphigus, scleroderma, and mycosis fungoides vary considerably and the interested physician is advised to consult the latest literature for suggested therapeutic regimens.

Adrenogenital Syndrome—It will effectively suppress adrenocortical hypersecretion with prompt decreases in urinary 17-ketosteroid levels. Optimal maintenance doses must be determined for each individual as reflected by continuation of normal urinary 17-ketosteroid levels. A dose of 0.75 to 1.5 mg. daily will usually provide the desired effect.

Bursitis—Soft tissue inflammations such as bursitis, synovitis, and tenosynovitis will respond favorably to corticosteroids. Initial daily doses of 1.5 to 3.0 mg. will provide a rather prompt and satisfactory result and short courses of therapy usually suffice. The majority of patients will respond satisfactorily to a single daily dose.