

Miscellaneous Diseases—The anti-inflammatory corticosteroids may provide a measure of relief in certain other diseases such as: pulmonary fibrosis, pulmonary emphysema, lupus erythematosus, nephrosis, ulcerative colitis, idiopathic thrombocytopenic purpura, and may provide a temporary palliative effect in lymphatic leukemia and lymphomas. It is contraindicated in metastatic carcinoma.

Dosage requirements for the above indications must be individualized since most of these diseases have a serious, if not greater prognosis, and vigorous therapy may be justified. The use of high doses will increase the incidence of undesirable side effects. If the risk is accepted, the patient must be carefully observed for their occurrence and treated accordingly.

As with all potent drugs the dosage of corticosteroids should be individualized. The best dose is the smallest dose which will produce adequate but not necessarily complete relief of symptoms. Higher doses or prolonged periods of therapy tend to produce an increased incidence of side effects and this risk must be balanced against anticipated benefits in every instance. Where large doses are required the patient should be carefully watched for the appearance of the classical signs of overdosage when it may become necessary to decrease the dose or stop therapy.

Corticosteroids are usually given in divided doses. Clinical studies, however, have convincingly demonstrated that a single daily dose is effective for the majority of patients suffering from hypersensitivity states, dermatoses, bursitis or other mild connective tissue diseases, etc. While the response has been less striking in rheumatoid arthritis the incidence of effective control is sufficiently high to make this regimen worthy of trial. Single doses are best given in the morning unless clinical reasons dictate an evening dose.

It is advisable, when discontinuing corticosteroid therapy, to reduce dosage gradually and not abruptly. The administration of ACT II during the withdrawal period may help to accelerate the return of normal adrenocortical function.

Patients currently being treated with other corticosteroids may be transferred conveniently to this agent using the following dosage equivalents:

0.75 dexamethasone equivalent to:

- 25 mg. cortisone.
- 20 mg. hydrocortisone
- 5 mg. prednisone or prednisolone.
- 4 mg. methylprednisolone
- 4 mg. triamcinolone.

Caution: Federal law prohibits dispensing without prescription.

Supplied:

- 0.50 mg. tablets (yellow, scored), bottles of 30 and 500.
- 0.75 mg. tablets (white, scored), bottles of 100 and 500.
- 1.5 mg. tablets (peach, scored), bottles of 50.
- 0.50 mg./5 ml. elixir (alcohol 5%), bottles of 120 ml.

HEXADROL® PHOSPHATE INJECTION

(Dexamethasone Sodium Phosphate, N.F.)

Description—Hexadrol phosphate injection (dexamethasone sodium phosphate N.F.) is a water-soluble inorganic ester of dexamethasone which produces a rapid response even when injected intramuscularly. Chemically it is 9- α -fluoro, 16- α -methyl prednisolone 21-phosphate.

Each cubic centimeter contains:

Dexamethasone sodium phosphate, N.F.	4.0 mg.
Sodium Bisulphite U.S.P.	3.5 mg.
Sodium Citrate U.S.P.	10.0 mg.
Sodium Chloride U.S.P.	3.2 mg.
Disodium ethylene diamine tetra-acetate	0.1 mg.
Methylparaben U.S.P.	0.85 mg.
Propylparaben U.S.P.	0.15 mg.
Sodium hydroxide U.S.P. q.s.	to pH 7.7.
Water for Injection U.S.P. q.s.	1.0 cc.

Action and Uses—Dexamethasone sodium phosphate N.F. exhibits the intrinsic properties and hormonal effects of the parent substance and other corticosteroids. When administered intravenously, intramuscularly, intrasynovially or locally it