(i) Tendinitis.
(j) Localized myositis
(k) Heloma.

Contraindications—Tuberculosis, active, latent or questionably healed, herpes simplex of the eye and acute psychosis are usually absolute contraindications. Infectious arthritis is also an absolute contraindication to intra-articular injection. Peptic ulcer, psychotic tendencies, diverticulitis, fresh intestinal anastomoses, thromboembolic tendencies, local or systemic infections including fungal and exanthematous diseases, osteoporosis, renal insufficiency are relative contraindications. Corticosteroids have produced teratogenic effects in animal fetuses and for this reason dexamethasone should not be used in pregnant women except in severe disease. In the event that corticosteroids must be used in pregnant women newborn infants should be carefully observed for possible postnatal hypoadrenalism.

Precautions and Side Effects—Hexadrol phosphate injection (dexamethasone sodium phosphate N.F.) is usually given for short periods of time and the known signs of corticoid overdosage are rarely seen. The appearance and nature of untoward effects depends largely on dosage, duration of treatment, and route of administration. *Faintness, weakness, nausea, dyspnea, weight gain, increased appetite and mental stimulation have been reported as immediate or short-term side effects following its parenteral use.* Untoward systemic hormonal effects from the intrasynovial or soft tissue injection of this agent are not anticipated when injections are few in number or are given at infrequent intervals.

All corticosteroids, including dexamethasone, produce the same type of side effects and these include: Cushing-like syndrome, purpura or petechiae, electrolyte imbalance, insomnia, osteoporosis, spontaneous fractures, negative nitrogen balance, peptic ulcer, euphoria, psychic disturbances, menstrual irregularities, weight changes, hyperglycemia, hypertension, edema, bloating or gastric distress, aseptic necrosis of the hip, and hirsutism. Vascular changes such as polyarteritis nodosa or an increased tendency for thrombophlebitis have been reported. Ulcerative esophagitis and acute pancreatitis have occurred during, and may be related to, corticosteroid therapy. *Some corticosteroids such as the fluoro analogues of prednisolone appear to exert a relatively greater muscle wasting effect.* The incidence, type and severity of untoward reactions is usually related to the size of the dose and duration of therapy. For example, prolonged use of corticosteroids may also cause growth suppression (reversible on withdrawal) in children, delayed wound healing, or posterior subcapsular cataracts in adults. Because of the greatly enhanced anti-inflammatory activity of dexamethasone, lower doses can be used thus preventing or minimizing abnormal salt and water retention or potassium loss, Periodic serum potassium determinations are advised during prolonged therapy

It may be used as adjuvant therapy in certain infectious diseases providing such infections are adequately controlled by appropriate antibiotics or chemotherapeutic agents. It must be remembered that the anti-inflammatory effects of corticosteroids may mask signs of infection and such patients should be carefully observed. While average doses will usually not increase insulin requirements in controlled diabetics, when the drug is used in such patients, they should be observed closely for evidences of increased hyperglycemia or glycosuria. Periodic determinations of blood sugar during prolonged therapy are advised.

Post-injection flare-up of joint pain may sometimes be seen following intra-articular injection. Instability of a joint following repeated intra-articular injections is a rare occurrence.

It is safest to assume that prolonged therapy will result in depression of adrenocortical function. For this reason the drug should be withdrawn gradually when treatment is to be discontinued. It may be advisable to administer ACTH during this period to hasten the return of normal function. Should the patient be subjected to surgery, severe trauma, or shock within one year following withdrawal it may be advisable to give a temporary course of corticosteroid therapy. If this product is employed, supplementary salt and/or desoxycorticosterone should be used. Because of supplemental therapy required, dexamethasone is not the drug of choice in adrenal insufficiency.

Dosage—The dose for intramuscular or intravenous administration varies from 4 to 20 mg, depending on the nature and severity of the disease being treated. *Intravenous doses exceeding 8 mg. (2cc) should be given slowly over a period of one minute. The initial dose may be repeated as necessary until the desired response is noted but the daily dose, with few exceptions, need not exceed 80 mg.*