

Diabetes mellitus, hypertension and congestive heart failure may be aggravated by the administration of corticoids. However, concomitant administration of Medrol with diuretics may be beneficial in patients with cardiac edema. Negative nitrogen balance may occur with protracted maintenance therapy. Measures to counteract persistent nitrogen loss include a high protein intake and the administration, when indicated, of a suitable anabolic agent. Likewise, ecchymotic manifestations have occasionally been reported. If such reactions are serious or distressing to the patient, reduction in dosage or discontinuance of methylprednisolone therapy may be indicated.

While current investigations indicate that muscle weakness in patients receiving corticoids may occur in the presence of normal or low potassium levels and may be due to a disturbance in muscle metabolism, data indicate that the incidence of this complication is low with Medrol. This effect should be kept in mind and periodic serum potassium determinations performed in patients on prolonged therapy. In some instances, steroid-induced myopathy has actually improved when patients have been transferred to a predosteroid such as Medrol from fluorinated steroids containing the 9- α -fluoro configuration.

Because Medrol manifests little sodium retaining activity, the usual sign of cortisone or hydrocortisone overdosage (i.e., increase in body weight due to fluid retention) is not a reliable index of overdosage. Hence, recommended dose levels should not be exceeded, and all patients should be under close medical supervision. All precautions pertinent to the use of prednisolone apply.

While corticoids may be considered as effective therapy in polyarteritis nodosa, current data indicates that such therapy may have an undesirable effect and may cause lesions characteristic of the disease. Likewise, data indicates that the use of corticoids may in some instances induce acute pancreatitis. The development of posterior subcapsular cataracts has been associated with prolonged, high dosage corticoid therapy. To minimize this effect, doses should be kept as low as possible when administered for prolonged periods.

Retardation of linear growth has been noted in children receiving corticoids for 6 months or longer. With methylprednisolone this has been noted with doses of 5 mg. per square meter of body surface per day or greater. Retardation is usually proportional to dose and following cessation of therapy, the growth rate may be accelerated. The growth of children receiving prolonged therapy should be observed carefully. If growth has been retarded, the dose should be reduced sufficiently to permit recovery before epiphyseal closure.

Continued supervision of the patient after cessation of Medrol (methylprednisolone) therapy is essential, since there may be a sudden reappearance of severe manifestations of the disease for which the patient was treated.

Warning: Because of its inhibitory effect on fibroplasia, methylprednisolone may mask the signs of infection and enhance dissemination of the infecting organism. Hence, all patients receiving methylprednisolone should be watched for evidence of intercurrent infection. Should infection occur, it must be brought under control by use of appropriate antibacterial measures, or administration of methylprednisolone should be discontinued.

Since methylprednisolone suppresses endogenous adrenocortical activity, it is highly important that the patient receiving methylprednisolone be under careful observation not only during the course of treatment but for some time after treatment is terminated. Adequate adrenocortical supportive therapy with cortisone or hydrocortisone, and including ACTH, must be employed promptly if the patient is subjected to any unusual stress such as surgery, trauma, or severe infection.

Tuberculosis: Use of corticoid therapy as an adjunct in pulmonary or meningeal tuberculosis must be based on careful assessment of all factors. Such therapy should not be instituted unless the tubercle bacilli are shown to be sensitive to the antituberculosis agent. Use of adequate and effective antituberculosis therapy currently with corticoid therapy is mandatory. When the tuberculous condition is complicated by fungal infections, corticoid therapy is contraindicated. "Rebound" fever, joint pains and temporary deterioration of pulmonary lesions as indicated by x-ray may follow corticoid withdrawal. Hypersensitivity to the antituberculosis agent may be unmasked by withdrawal of corticoid.

Hematological Disorders: Therapy with methylprednisolone has been effective in producing remissions with certain types of leukemia, in producing symptomatic improvement of patients with other lymphomatous diseases and in thrombocytopenia and hemolytic anemia. As a general rule, the therapy with corticosteroids produces remissions more frequently in acute lymphatic leukemia