Contraindications: "Absolute Contraindications": Tuberculosis (active, healed or questionably healed), ocular herpes simplex, and acute psychosis are usually absolute contraindications to corticotropin therapy. Corticotropin is of no value in patients with Addison's Disease or after adrenalectomy since its action depends on the integrity of the adrenal cortex.

"Relative Contraindications": (1) Relative contraindications are Cushing's Disease, congestive heart failure, diverticulitis, fresh intestinal anastomoses, active or latent peptic ulcer, renal insufficiency, hypertension, thromboembolic tendencies, osteoporosis, diabetes mellitus, psychotic tendencies and acute or chronic infections (especially varicella or vaccinia) as well as other exanthematous and fungal diseases. (2) Pregnancy is a relative contraindication to corticotropin therapy, particularly during the first trimester, because fetal abnormalities have been observed in experimental animals. (3) If corticotropin is used in the above conditions, the risks should be weighed against the possible benefits.

Warning: Skin testing should be considered prior to treatment of patients with known or suspected sensitivities to corticotropin (which is a polypeptide) or porcine proteins. It is recommended that all patients be observed for a period of at least 15 minutes following administration of corticotropin. Epinephrine 1 : 1000 for emergency treatment should be available.

Precautions: (1) Corticotropin should be given only with full knowledge of the characteristic activity of, and the varied responses to, this preparation. (2) Average and large doses of corticotropin can cause elevation of blood pressure, salt and water retention, and increased potassium and calcium excretion. *The hypertension may be transitory during a period of electrolyte and water retention. Observe blood pressure responses until the maintenance dose is established.* Dietary salt restriction and potassium supplementation may be necessary. *If this does not control fluid retention, decrease the dose, omit a few injections until diuresis occurs, administer a diuretic, or consider discontinuation of therapy. Daily weights should be charted as a guide to abnormal weight gains.* Muscle weakness, fatigue or paresthesias may be a reflection of potassium deficiency, but are seldom observed if a potassium supplement is added to the diet. *EKG's or serum potassium levels are recommended guides if ACTH or corticoids are administered at high dosage levels for prolonged periods. If necessary, decrease the dosage or temporarily interrupt treatment and resume at a later date on a high potassium regimen.* (3) *Corticotropin may mask the signs of infection and enhance dissemination of the infecting organism. Hence all patients receiving corticotropin should be watched for evidence of intercurrent infection.* Chest x-rays should be done at regular intervals during prolonged therapy. *Should infection occur, initiate vigorous, appropriate anti-infective therapy. Abrupt cessation of corticotropin should be avoided if possible because of the danger of superimposing adrenocortical insufficiency on the infectious process.* (4) Since spontaneous remission of some diseases, such as rheumatoid arthritis, may occur during pregnancy, every effort should be made to avoid hormone treatment in pregnancy. (5) To avoid relative pituitary hypofunction, corticotropin therapy should be terminated gradually, particularly when patients are receiving large doses or have undergone prolonged treatment. Furthermore, if such patients are subjected to undue stress, such as surgery or trauma, while being treated or within one year after treatment has been terminated, hormone therapy should be augmented or reinstated and continued for the duration of the stress period and immediately following it. It is preferable to use corticotropin and/or cortisone or hydrocortisone in the immediate preoperative and postoperative periods. (6) Continued supervision of the patient after cessation of corticotropin is essential, since there may be a sudden reappearance of severe manifestations of the disease for which the patient was treated. (7) *Long-term corticotropin therapy may be accompanied by gastric hyperacidity and/or peptic ulcer. It is recommended, therefore, that patients with a history of peptic ulcer be placed on an ulcer regimen (including administration of an antacid) as a prophylactic measure.* Peptic ulcer patients complaining of gastric distress should be the subjects of appropriate x-ray examinations of the gastrointestinal tract. (8) Corticotropin may aggravate diabetes mellitus so that higher insulin dosage may become necessary or manifestations of latent diabetes mellitus may be precipitated. *Frequent urine sugar determinations and two hour postprandial blood sugar determinations are recommended during the period of dosage adjustment.* (9) Phychotic changes may be observed. *If exaggerated euphoria, nervousness, pronounced insomnia or depression occur, reduce or discontinue therapy and administer sedatives as indicated.*