indwelling infection is not known. The contribution of the disease and/or the corticosteroid treatment to the risk is not known. If exposed to chicken pox, patients with varicella immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with immune globulin (IG) may be indicated. See the respective package insert for complete VZIG and Biotherapeutic Information. If chicken pox develops, treatment with antiviral agents should be considered.

Ophthalmologic: Uncommon or infrequent: Dry eye, ocular irritation.

Cardiovascular: Likely to occur with protracted therapy, particularly in patients with cardiac or other disease(s) predisposing to heart failure who are being treated with corticosteroids, since patients with these conditions are more susceptible to the development of heart failure in response to corticosteroids. If heart failure develops, the drug should be discontinued as soon as feasible. In rare circumstances, digitalis may be required to treat slow or irregular heart rhythms that may occur as a consequence of heart failure.

Drug Interactions: In patients treated for the management of the disease in conjunction with an appropriate adrenocortical substitute regimen. If corticosteroids are administered to patients with latent or active tuberculosis, the possibility of the development of drug-resistant strains of the tubercle bacillus is increased.

Gastrointestinal: Nausea, vomiting, anorexia, epigastric distress, and dyspepsia. In some patients, abdominal pain may be so severe as to simulate appendicitis. Mild elevation of liver enzymes may also occur.

Coughing, wheezing, dyspnea, and other symptoms of bronchospasm; hypokalemia; hyperglycemia; and loss of potassium from the GI tract. In some patients with adrenocortical insufficiency, corticosteroids may precipitate adrenocortical insufficiency by blunting the physiologic response to hypoglycemia. Corticosteroids should not be used in cerebral edema due to head injury or intracranial tumors, in the presence of or as a substitute for anticonvulsant drugs in the treatment of epilepsy.

Cardiovascular: Adverse cardiovascular effects include decreases in the peripheral vascular resistance, increases in blood volume and blood pressure, and edema in dependent areas. If these develop, the drug should be discontinued as soon as feasible.

Depression: Corticosteroids may also increase or worsen preexisting depression. Psychological effects of corticosteroids consist of insomnia, nervousness, mood changes, and, rarely, mania. If these occur, the drug should be discontinued as soon as feasible.

Neuropsychiatric: The potential for serious adverse reactions in patients who are treated with corticosteroids or other agents that suppress the immune system must be considered. Some of these reactions may be hypertensive, hyperglycemic, or hyperlipidemic. However, the reactions with corticosteroids may be more severe, requiring changes in therapy or hospitalization. Corticosteroids may also increase the frequency or severity of ischemic complications of diabetes mellitus. Corticosteroids should therefore be used in patients with active or latent tuberculosis only if the potential benefits outweigh the potential risks.

Drug Interactions: Corticosteroids should be discontinued and adequate medical care should be rendered with appropriate supportive measures. Drug Interactions: Increased activity of both cyclosporin and corticosteroids may occur when these are used concurrently. Concomitant use has been reported with this concurrent use.
Endocrine: Decreased adrenal cortex function; development of subcutaneous fat, truncal fat, increased requirements for insulin or oral hypoglycemic agents in diabetic patients, manifestations of latent diabetes mellitus, menstrual irregularities, secondary adrenal and pituitary unresponsiveness and atrophy in both males and females, loss of hair, adrenal insufficiency in times of stress, an anemia, surgery or illness, suppression of growth in children.

Fluid and Electrolyte Disturbances: Congestive heart failure in susceptible patients; fluid retention; hypertension; hypokalemia; acidosis; decreased serum sodium.

Gastrointestinal: Abdominal distention; diarreal; nausea; vomiting; diarrhea; hepatomegaly; fever; cramping; abdominal discomfort; anorexia; weight gain; constipation; dry mouth.

Hematologic: Negative changes in blood cells: anemia; leukopenia; thrombocytopenia; increased bruising; increased blood coagulation; purpura; hemolytic anemia; agranulocytosis; aplastic anemia; eosinophilia.

Hypertrophic cardiomyopathy in hypertensive patients. Dissection of aortic aneurysm or aortic dissection may occur, especially in patients with hypertension.

Renal: Sodium, potassium, and chloride retention.

Neurologic: Compressive neuropathy; headache, paresthesias, mental depression, muscle weakness, symptoms of cerebrovascular insufficiency; mental depression; emotional lability; confusion; hallucinations; paranoia; psychosis; and delirium.

Ophthalmic: Ocular hypertension, optic neuritis, papilledema, exudates; retinal hemorrhages; vitreous floaters; macular edema; cataracts; iritis; retinal detachment.

Osteoporosis.

Corticosteroids may suppress reactions to skin tests. Skin test results may be affected by corticosteroid treatment even after the drug has been discontinued. Immunosuppressive effects of corticosteroids may prevent adequate recovery from trauma, surgery, or infection and other conditions that normally result in increased stress.

Cardiovascular: Hypertension.

Supraventricular tachycardia.

Arrhythmia.

Cardiac failure.

Hypertrophic cardiomyopathy.

Cardiac arrest.

Stress Ulcer:

Rash:

Erythema nodosum.

Acne.

Facial erythema.

Increased sweating.

Reddening of skin.

Erythema.

Pruritus.

Pruritus ani.

Increased sebum production.

Ecchymoses.

Acne vulgaris.

Thermal injury.

Bruises.

Pigmentation.

Cushingoid features.

Depot injection site reactions.

Cramps.

Abdominal pain.

Nausea.

Vomiting.

Diabetes Mellitus.

Metabolic: Changes in carbohydrate metabolism, changes in body fat and muscle distribution, hyperglycemia in normal glucose tolerant individuals, impaired glucose tolerance in patients with impaired glucose tolerance prior to corticosteroid therapy, hyperuricemia, decrease in plasma noradrenaline levels, decrease in plasma renin activity, increase in plasma aldosterone levels, increase in plasma fatty acids levels, increase in plasma cholesterol and triglyceride levels, increase in low density lipoprotein levels, increase in total cholesterol levels, increase in LDL-cholesterol levels, increase in triglycerides levels, decrease in HDL-cholesterol levels.

Hypertension.

Corticosteroids may increase blood glucose levels in patients with latent diabetes mellitus and may exacerbate symptoms in diabetic patients. In diabetic patients, the initial dose of prednisolone is 0.3 to 0.8 mg/kg per day or 40 to 60 mg/m2 per day, and should be maintained at the lowest dose required to control the clinical status of the patient. In patients with latent diabetes mellitus, doses of prednisolone should be adjusted to maintain a normal fasting blood sugar.

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