Pfizer

ڈیپو-میڈرول

Depo-Medrol®

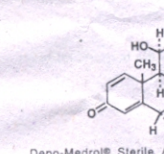
(Methylprednisolone Acetate)

Sterile Aqueous Suspension

DESCRIPTION

Depo-Medrol® is an anti-inflammatory glucocorticoid for intramuscular, intra-articular, soft tissue or intralesional injection. It is available as: 40 mg / mL; 80 mg / 2 mL.

Each mL of these preparations contains: Methylprednisolone acetate 40 mg, Polyethylene glycol 3350, Myristyl-gamma-picolinium chloride, Sodium Chloride, Water for injection q.s. The chemical name for methylprednisolone acetate is pregna-1,4-diene-3,20-dione, 21(acetyloxy)-11,17-dihydroxy-6-methyl-,(6α,11β)-and the molecular weight is 416.51.



Depo-Medrol® Sterile Aqueous Suspension contains methylprednisolone acetate which is the 6-methyl derivative of prednisolone. Methylprednisolone acetate is a white or practically white, odorless, crystalline powder which melts at about 215° with some decomposition. It is soluble in dioxane, sparingly soluble in acetone, in alcohol, in chloroform, and in methanol, and slightly soluble in ether. It is practically insoluble in water.

THERAPEUTIC INDICATIONS

A. FOR INTRAMUSCULAR ADMINISTRATION

When oral therapy is not feasible and the strength, dosage form, and route of administration of the drug reasonably lend the preparation to the treatment of the condition, the intramuscular use of Depo-Medrol® Sterile Aqueous Suspension (methylprednisolone acetate) is indicated as follows:

1. ***Endocrine Disorders***
- Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone is the drug of choice; synthetic analogs may be used in conjunction with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is of particular importance).
- Acute adrenocortical insufficiency (hydrocortisone or cortisone is the drug of choice, mineralocorticoid supplementation may be necessary, particularly when synthetic analogs are used).
- Congenital adrenal hyperplasia
- Hypercalcemia associated with cancer
- Nonsuppurative thyroiditis

2. ***Rheumatic Disorders:*** As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in:
- Post-traumatic osteoarthritis
- Synovitis of osteoarthritis
- Epicondylitis
- Acute nonspecific tenosynovitis
- Rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy)
- Psoriatic arthritis
- Acute gouty arthritis
- Ankylosing spondylitis
- Acute and subacute bursitis

3. ***Collagen Diseases:*** During an exacerbation or as maintenance therapy in selected cases of:
- Systemic lupus erythematosus
- Systemic dermatomyositis (polymyositis)
- Acute rheumatic carditis

4. ***Dermatologic Diseases***
- Pemphigus
- Bullous dermatitis
- Severe erythema multiforme herpetiformis (Stevens-Johnson syndrome)
- Severe seborrheic dermatitis
- Exfoliative dermatitis
- Mycosis fungoides
- Severe psoriasis

5. ***Allergic States:*** Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment in:
- Bronchial asthma
- Drug hypersensitivity reactions
- Urticarial transfusion reactions
- Contact dermatitis
- Atopic dermatitis
- Serum sickness
- Seasonal or perennial allergic rhinitis
- Acute non-infectious laryngeal edema (epinephrine is the drug of first choice)

6. ***Ophthalmic Diseases:*** Severe acute and chronic allergic and inflammatory processes involving the eye, such as:
- Herpes zoster ophthalmicus
- Drug hypersensitivity reactions
- Iritis, iridocyclitis
- Anterior segment inflammation
- Chorioretinitis
- Allergic conjunctivitis
- Diffuse posterior uveitis
- Allergic corneal marginal ulcers
- Optic neuritis
- Keratitis

7. ***Gastrointestinal Diseases:*** To tide the patient over a critical period of the disease in:
- Ulcerative colitis (systemic therapy)
- Regional enteritis (systemic therapy)

8. ***Respiratory Diseases***
- Fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate anti- tuberculous chemotherapy
- Symptomatic sarcoidosis
- Berylliosis
- Loeffler's syndrome not manageable by other means
- Aspiration pneumonitis

9. ***Hematologic Disorders***
- Acquired (autoimmune) hemolytic anemia
- Erythroblastopenia (RBC anemia)
- Secondary thrombocytopenia in adults
- Congenital (erythroid) hypoplastic anemia

10. ***Neoplastic Diseases:*** For palliative management of:
- Leukemias and lymphomas
- Acute leukemia of childhood

11. ***Edematous States:*** To induce diuresis or remission of proteinuria in the nephrotic syndrome, without uremia, of the idiopathic type or that due to lupus erythematosus.

12. ***Nervous System***
- Acute exacerbations of multiple sclerosis.

13. ***Miscellaneous***
- Tuberculous meningitis with subarachnoid block or impending block when used concurrently with appropriate anti-tuberculous chemotherapy.
- Trichinosis with neurologic or myocardial involvement.

B. FOR INTRA-SYNOVIAL OR SOFT TISSUE ADMINISTRATION (including periarticular and intrabursal - SEE WARNINGS)

Depo-Medrol® is indicated as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in:
- Synovitis of osteoarthritis
- Epicondylitis
- Rheumatoid arthritis
- Acute nonspecific tenosynovitis
- Acute and subacute bursitis
- Post-traumatic osteoarthritis
- Acute gouty arthritis

C. FOR INTRALESIONAL ADMINISTRATION

Depo-Medrol® is indicated for intralesional use in the following conditions:
- Keloids, Localized hypertrophic, infiltrated, inflammatory lesions of:
- Lichen planus, psoriatic plaques
- Discoid lupus erythematosus
- Necrobiosis lipodica diabeticorum
- Granuloma annulare
- Lichen Simplex chronicus (neurodermatitis)
- Alopecia areata

Depo-Medrol® may also be useful in cystic tumors or an aponeurosis or tendon (ganglia).

D. FOR INTRARECTAL INSTALLATION
- Ulcerative colitis

POSOLOGY AND METHOD OF ADMINISTRATION

Because of possible physical incompatibilities, Depo-medrol® Sterile Aqueous Suspension (methylprednisolone acetate) should not be diluted or mixed with other solutions. Parenteral suspensions should be inspected visually for any foreign particulate matter and discoloration prior to administration whenever drug product and container permit.

Administration for Local Effect

Therapy with Depo-Medrol® does not obviate the need for the conventional measures usually employed. Although this method of treatment will ameliorate symptoms, it is in no sense a cure and the hormone has no effect on the cause of the inflammation.

1. ***Rheumatoid and Osteoarthritis.*** The dose for intra-articular administration depends upon the size of the joint and varies with the severity of the condition in the individual patient. In chronic cases, injections may be repeated at intervals ranging from one to five or more weeks depending upon the degree of relief obtained from the initial injection.

The doses in the following table are given as a general guide:

Size of Joint	Examples	Range of Dosage
Large	Knees Ankles Shoulders	20-80 mg
Medium	Elbows Wrists	10-40 mg
Small	Metacarpophalangeal Interphalangeal Sternoclavicular Acromioclavicular	4-10 mg

Procedure: It is recommended that the anatomy of the joint involved be reviewed before attempting intra-articular injection. In order to obtain the full anti-inflammatory effect, it is important that the injection be made into the synovial space. Employing the same sterile technique as for a lumbar puncture, a sterile 20 to 24 gauge needle (on a dry syringe) is quickly inserted into the synovial cavity. Procaine infiltration is elective. The aspiration of only a few drops of joint fluid proves the joint space has been entered by the needle.

The injection site for each joint is determined by that location where the synovial cavity is most superficial and most free of large vessels and nerves. With the needle in place, the aspirating syringe is removed and replaced by a second syringe containing the desired amount of Depo-Medrol®. The plunger is then pulled outward slightly to aspirate synovial fluid and to make sure the needle is still in the synovial space. After injection, the joint is moved gently a few times to aid mixing of the synovial fluid and the suspension. The site is covered with a small sterile dressing.

Suitable sites for intra-articular injection are the knee, ankle, wrist, elbow, shoulder, phalangeal, and hip joints. Since difficulty is occasionally encountered in entering the hip joint, precautions should be taken to avoid any large blood vessels in the area. Joints not suitable for injection are those that are anatomically inaccessible, such as the spinal joints and those like the sacroiliac joints that are devoid of synovial space. Treatment failures are most frequently the result of failure to enter the joint space. Little or no benefit follows injection into surrounding tissue. If failures occur when injections into the synovial spaces are certain, as determined by aspiration of fluid, repeated injections are usually futile.

Local therapy does not alter the underlying disease process, and whenever possible comprehensive therapy including physiotherapy and orthopedic correction should be employed. Following intra-articular corticosteroid therapy, care should be taken to avoid overuse of joints in which symptomatic benefit has been obtained. Negligence in this matter may permit an increase in joint deterioration that will more than offset the beneficial effects of the steroid.

Unstable joints should not be injected. Repeated intra-articular injection may in some cases result in instability of the joint. X-ray follow-up is suggested in selected cases to detect deterioration.

If a local anesthetic is used prior to injection of Depo-Medrol®, the anesthetic package insert should be read carefully and all the precautions observed.

2. ***Bursitis.*** The area around the injection site is prepared in a sterile way and a wheal at the site made with 1 percent procaine hydrochloride solution. A 20 to 24 gauge needle attached to a dry syringe is inserted into the bursa and the fluid aspirated. The needle is left in place and the aspirating syringe changed for a small syringe containing the desired dose. After injection, the needle is withdrawn and a small dressing applied.

3. ***Miscellaneous: Ganglion, Tendinitis, Epicondylitis.*** In the treatment of conditions such as tendinitis or tenosynovitis, care should be taken, following application of a suitable antiseptic to the overlying skin, to inject the suspension into the tendon sheath rather than into the substance of the tendon. The tendon may be readily palpated when placed on a stretch. When treating conditions such as epicondylitis, the area of greatest tenderness should be outlined carefully and the suspension infiltrated into the area. For ganglia of the tendon sheaths, the suspension is injected directly into the cyst. In many cases, a single injection causes a marked decrease in the size of the cystic tumor and may effect disappearance. The usual sterile precautions should be observed, of course, with each injection.

The dose in the treatment of the various conditions of the tendinous or bursal structures listed above varies with the condition being treated and ranges from 4 to 30 mg. In recent or chronic conditions, repeated injections may be necessary.

4. ***Injections for Local Effect in Dermatologic Conditions.*** Following cleansing with an appropriate antiseptic such as 70% alcohol, 20 to 60 mg of the suspension is injected into the lesion. It may be necessary to distribute doses ranging from 20 to 40 mg by repeated local injections in the case of large lesions. Care should be taken to avoid injection of sufficient material to cause blanching since this may be followed by a small slough. One to four injections at variable empty-of, the intervals between injections varying with the type of lesion being treated and the duration of improvement produced by the initial injection.

The following statement refers to the benzyl alcohol formulation only:

When multidose vials are used, special care to prevent contamination of the contents is essential (see WARNINGS).

Administration for Systemic Effect

The intramuscular dosage will vary with the condition being treated. When a prolonged effect is desired, the weekly dose may be calculated by multiplying the daily oral dose by 7 and given as a singular intramuscular injection.

Dosage must be individualized according to the severity of the disease and response of the patient. For infants and children, the recommended dosage will have to be reduced, but dosage should be governed by the severity of the condition rather than by strict adherence to the ratio indicated by age or body weight.

Hormone therapy is adjunct to, and not a replacement for, conventional therapy. Dosage must be decreased or discontinued gradually when the drug has been administered for more than a few days. The severity, prognosis and expected duration of the disease and the reaction of the patient to medication are primary factors in determining dosage. If a period of spontaneous remission occurs in a chronic condition, treatment should be discontinued. Routine laboratory studies, such as urinalysis, two-hour postprandial blood sugar, determination of blood pressure and body weight, and a chest x-ray should be made at regular intervals during prolonged therapy. Upper GI x-rays are desirable in patients with an ulcer history or significant dyspepsia.

In patients with the adrenogenital syndrome, a single intramuscular injection of 40 mg every two weeks may be adequate. For maintenance of patients with rheumatoid arthritis, the weekly intramuscular dose will vary from 40 to 120 mg. The usual dosage for patients with dermatologic lesions benefitted by systemic corticoid therapy is 40 to 120 mg of methylprednisolone acetate administered intramuscularly at weekly intervals for one to four weeks. In acute severe dermatitis due to poison ivy, relief may result within 8 to 12 hours following intramuscular administration of a single dose of 80 to 120 mg.

In chronic contact dermatitis, repeated injections at 5 to 10 day intervals may be necessary. In seborrheic dermatitis, a weekly dose of 80 mg may be adequate to control the condition.

Following IM administration of 80 to 120 mg to asthmatic patients, relief may result within 6 to 48 hours and persist for several days to two weeks. Similarly in patients with allergic rhinitis (hay fever) an intramuscular dose of 80 to 120 mg may be followed by relief of coryzal symptoms within six hours persisting for several days to three weeks.

If signs of stress are associated with the condition being treated, the dosage of the suspension should be increased. If a rapid hormonal effect of maximum intensity is required, the intravenous administration of highly soluble methylprednisolone sodium succinate is indicated.

Intra-rectal Administration
Depo-Medrol® Sterile Aqueous Suspension in doses of 40 to 120 mg administered as retention enemas or by continuous drip three to seven times weekly for periods of two or more weeks, have been shown to be a useful adjunct in the treatment of some patients with ulcerative colitis. Many patients can be controlled with 40 mg of Depo-Medrol® Sterile Aqueous Suspension administered in from 30-300 ml of water depending upon the degree of involvement of the inflamed colonic mucosa. Other accepted therapeutic measures should, of course, be instituted.

CONTRAINDICATIONS
- Intrathecal administration
- Intravenous administration
- Systemic fungal infections
- Known hypersensitivity to components

WARNINGS
Either
MGPC formulation
This product is not suitable for multidose use. Following administration of the desired dose, any remaining suspension should be discarded.
or
Benzyl Alcohol Formulation
This product contains benzyl alcohol which is potentially toxic when administered locally to neural tissue.

Multidose use of Depo-Medrol® from a single vial requires special care to avoid contamination. Although initially sterile, any multidose use of vials may lead to contamination unless strict aseptic technique is observed. Particular care, such as use of disposable sterile syringes and needles, is necessary.

While crystals of adrenal steroids in the dermis suppress inflammatory reaction, their presence may cause disintegration of the cellular elements and physicochemical changes in the ground substance of the connective tissue. The resultant infrequently occurring dermal and/or subdermal changes may form depressions in the skin at the injection site. The degree to which this reaction occurs will vary with the amount of adrenal steroid injected. Regeneration is usually complete within a few months or after all crystals of the adrenal steroid have been absorbed.

In order to minimize the incidence of dermal and subdermal atrophy, care must be exercised not to exceed recommended doses in injections. Multiple small injections into the area of the lesion should be made whenever possible. The technique of intra-synovial and intramuscular injection should include precautions against injection or leakage into the dermis. Injection into the deltoid muscle should be avoided because of a high incidence of subcutaneous atrophy.

Depo-Medrol® should not be administered by any route other than those listed under INDICATIONS. It is critical that, during administration of Depo-Medrol®, appropriate technique be used and care taken to assure proper placement of drug.

Administration by other than indicated routes has been associated with reports of serious medical events including: arachnoiditis, meningitis, paraparesis/paraplegia, sensory disturbances, bowel/bladder dysfunction, seizures, visual impairment including blindness, ocular and periocular inflammation, and residue or slough at injection site.

In patients on corticosteroid therapy subjected to unusual stress, increased dosage of rapidly acting corticosteroids before, during and after the stressful situation is indicated.

Corticosteroids may mask some signs of infection, and new infections may appear during their use. There may be decreased resistance and inability to localize infection when corticosteroids are used. Infections with any pathogen including viral, bacterial, fungal, protozoan or helminthic infections, in any location in the body, may be associated with the use of corticosteroids alone or in combination with other immunosuppressive agents that affect cellular immunity, humoral immunity, or neutrophil function. These infections may be mild, but can be severe and at times fatal. With increasing doses of corticosteroids, the rate of occurrence of infectious complications increases. Do not use intra-synovially, intrabursally or intra-tendinous administration for local effect in the presence of acute infection.

Prolonged use of corticosteroids may produce posterior subcapsular cataracts, glaucoma with possible damage to the optic nerves, and may enhance the establishment of secondary ocular infections due to fungi or viruses.

Pediatric use: This product contains benzyl alcohol. Benzyl alcohol has been reported to be associated with a fatal gasping syndrome in premature infants.

Growth may be suppressed in children receiving long-term, daily-divided dose glucocorticoid therapy. The use of such a regimen should be restricted to those most serious indications.

Administration of live or live, attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids. Killed or inactivated vaccines may be administered to patients receiving immunosuppressive doses of corticosteroids; however, the response to such vaccines may be diminished. Indicated immunization procedures may be undertaken in patients receiving non-immunosuppressive doses of corticosteroids.

The use of Depo-Medrol® in active tuberculosis should be restricted to those cases of fulminating or disseminated tuberculosis in which the corticosteroid is used for the management of the disease in conjunction with appropriate antituberculosis regimen.

If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis. Because rare instances of anaphylactic reactions have occurred in patients receiving parenteral corticosteroid therapy, appropriate precautionary measures should be taken prior to administration, especially when the patient has a history of allergy to any drug.

Allergic skin reactions have been reported apparently related to the excipients in the formulation (see DESCRIPTION). Rarely has skin testing demonstrated a reaction to methylprednisolone acetate, per se.

PREGNANCY AND LACTATION: Some animal studies have shown that corticosteroids, when administered to the mother at high doses, may cause fetal malformations. Adequate human reproductive studies have not been done with corticosteroids. Therefore the use of this drug in pregnancy, nursing mothers, or women of child bearing potential requires that the benefits of the drug be carefully weighed against the potential risk to the mother and embryo or fetus. Since there is inadequate evidence of safety in human pregnancy, this drug should be used in pregnancy only if clearly needed.
Corticosteroids readily cross the placenta. Infants born of mothers who have received substantial doses of corticosteroids during pregnancy must be carefully observed and evaluated for signs of adrenal insufficiency. There are no known effects of corticosteroids on labor and delivery. Corticosteroids are excreted in breast milk.

PRECAUTIONS
General Precautions
The following paragraph refers to the benzyl alcohol formulation only.
- When multidose vials are used, special care to prevent contamination of the contents is essential. There is some evidence that benzalkonium chloride is not an adequate antiseptic for sterilizing the port of multidose vials. A povidone-iodine solution or similar product is recommended to cleanse the vial top prior to aspiration of contents. (See WARNINGS).
- Corticosteroids should be used cautiously in patients with ocular herpes simplex for fear of corneal perforation.
- Psychic derangements may appear when corticosteroids are used, ranging from euphoria, insomnia, mood swings, personality changes, and severe depression to frank psychotic manifestations. Also, existing emotional instability or psychotic tendencies may be aggravated by corticosteroids.
- Corticosteroids should be used with caution in nonspecific ulcerative colitis, if there is a probability of impending perforation, abscess or other pyogenic infection. Caution must also be used in diverticulitis, fresh intestinal anastomoses, active or latent peptic ulcer, renal insufficiency, hypertension, osteoporosis, and myasthenia gravis, when steroids are used as direct or adjunctive therapy.

The following additional precautions apply for parenteral corticosteroids. Intra-synovial injection of a corticosteroid may produce systemic as well as local effects.
- Appropriate examination of any joint fluid present is necessary to exclude a septic process.
- A marked increase in pain accompanied by local swelling, further restriction of joint motion, fever, and malaise are suggestive of septic arthritis. If this complication occurs and the diagnosis of sepsis is confirmed, appropriate antimicrobial therapy should be instituted.
- Local injection of a steroid into a previously infected joint is to be avoided.
- Corticosteroids should not be injected into unstable joints.
- Sterile technique is necessary to prevent infections or contamination.
- The slower rate of absorption by intramuscular administration should be recognized.

Although controlled clinical trials have shown corticosteroids to be effective in speeding the resolution of acute exacerbations of multiple sclerosis, they do not show that corticosteroids affect the ultimate outcome or natural history of the disease. The studies do show that relatively high doses of corticosteroids are necessary to demonstrate a significant effect. (See sectin **DOSAGE AND ADMINISTRATION**)

Since complications of treatment with glucocorticoids are dependent on the size of the dose and the duration of treatment, a risk/benefit decision must be made in each individual case as to dose and duration of treatment as to whether daily or intermittent therapy should be used.

Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy. Discontinuation of corticosteroids may result in clinical remission.

Carcinogenesis, mutagenesis, Impairment of fertility: No evidence exists showing that corticosteroids are carcinogenic, mutagenic or impair fertility.

DRUG INTERACTIONS
The pharmacokinetic interactions listed below are potentially clinically important. Mutual inhibition of metabolism occurs with concurrent use of cyclosporin and methylprednisolone, therefore it is possible that adverse events associated with the individual use of either drug may be more apt to occur. Convulsions have been reported with concurrent use of methylprednisolone and cyclosporin. Drugs that induce hepatic enzymes such as phenobarbital, phenytoin and rifampin may increase the clearance of methylprednisolone and may require increase in methylprednisolone dose to achieve the desired response. Drugs such as troleandomycin and ketoconazole may inhibit the metabolism of methylprednisolone and thus decrease its clearance. Therefore the dose of methylprednisolone should be titrated to avoid steroid toxicity. Methylprednisolone may increase the clearance of chronic high dose aspirin. This could lead to a decrease in salicylate serum levels or increase the risk of salicylate toxicity when methylprednisolone is withdrawn. Aspirin should be used cautiously in conjunction with corticosteroids in patients suffering from hypoprothrombinemia. The effect of methylprednisolone on oral anticoagulants is variable. There are reports of enhanced as well as diminished effects of anticoagulant when given concurrently with corticosteroids. Therefore coagulation indices should be monitored to maintain the desired anticoagulant effect.

UNDESIRABLE EFFECTS
NOTE: The following are typical for all systemic corticosteroids. Their inclusion in this list does not necessarily indicate that the specific event has been observed with this particular formulation.

Fluid and Electrolyte Disturbances
- Sodium Retention
- Congestive Heart Failure in susceptible patients
- Hypertension
- Fluid retention
- Potassium loss
- Hypokalemic alkalosis

Musculoskeletal
- Steroid myopathy
- Muscle weakness
- Osteoporosis
- Pathologic fractures
- Vertebral compression fractures
- Aseptic necrosis
- Tendon rupture, particularly of the Achilles tendon

Gastrointestinal
- Peptic ulceration with possible perforation and hemorrhage
- Gastric hemorrhage
- Pancreatitis
- Esophagitis
- Perforation of the bowel
- Increases in alanine transaminase (ALT, SGPT), aspartate transaminase (AST, SGOT) and alkaline phosphatase have been observed following corticosteroid treatment. These changes are usually small, not associated with any clinical syndrome and are reversible upon discontinuation.

Dermatologic
- Impaired wound healing
- Petechiae and ecchymosis
- Thin fragile skin

Metabolic
- Negative nitrogen balance due to protein catabolism

Neurological
- Increased intracranial pressure
- Psuedotumor cerebri
- Psychic derangements
- Seizures

Endocrine
- Menstrual irregularities
- Development of Cushingoid State
- Suppression of pituitary - adrenal axis
- Decreased carbohydrate tolerance
- Manifestation of latent diabetes mellitus
- Increased requirements for insulin or oral hypoglycemic agents in diabetics
- Suppression of growth in children

Ophthalmic
- Posterior subcapsular cataracts
- Increased intraocular pressure
- Exophthalmos

Immune System
- Masking of infections
- Latent infections becoming active
- Opportunistic infections
- Hypersensitivity reactions including anaphylaxis
- May suppress reactions to skin tests

The following additional reactions are related to parenteral corticosteroid therapy:
- Rare instances of blindness associated with intralesional therapy around the face and head
- Anaphylactic reaction or allergic reactions
- Post injection flare, following intra-synovial use
- Hyperpigmentation or hypopigmentation
- Charcot-like arthropathy
- Injection site infections following non sterile technique
- Subcutaneous and cutaneous atrophy
- Sterile abscess

OVERDOSAGE
There is no clinical syndrome of acute over dosage with Depo-Medrol® Sterile Aqueous Suspension (methylprednisolone acetate).

Repeated frequent doses (daily or several times per week) over a protracted period may result in a Cushingoid state.

SHELF LIFE
Depo-Medrol® should not be used beyond the expiry date.

HOW SUPPLIED
Depo-Medrol® is available in the following package sizes:
- Depo-Medrol® is Sterile Aqueous Suspension 40 mg / mL vial
- Depo-Medrol® is Sterile Aqueous Suspension 80 mg / 2mL vial

DOSAGE
Use as directed by the physician.

INSTRUCTIONS
Shake well before use.
Avoid exposure to heat, sunlight & freezing.
Store below 30°C.
Keep out of the reach of children.

CAUTION
To be sold on the prescription of a registered medical practitioner only.

خوراک: ڈاکٹری ہدایت کے مطابق استعمال کریں۔

ہدایات: استعمال سے قبل دوا کو ہلائیں۔

دوا کو گرمی، سورج کی روشنی اور جمنے سے بچائیں۔

دوا کو ۳۰ ڈگری سینٹی گریڈ سے کم درجہ حرارت پر رکھیں۔ بچوں کی پہنچ سے دور رکھیں۔

تاکید: صرف رجسٹرڈ میڈیکل پریکٹشنر کے نسخہ پر فروخت کریں۔

Pfizer

Manufactured by:
Pfizer Belgium NV, Rijksweg 12,
B-2870 Puurs, Belgium.

Packed by:
Pfizer Pakistan Ltd.
B-2, S.I.T.E., Karachi, Pakistan.

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