Part II

Summary of Product Characteristics

1 NAME OF THE MEDICINAL PRODUCT

Decadron 500 microgram Tablets

2 QUALITATIVE AND QUANTITATIVE COMPOSITION

Each tablet of 'Decadron' contains 500 micrograms Dexamethasone.
For excipients, see 6.1.

3 PHARMACEUTICAL FORM

Tablet
Round, white, half-scored tablet, marked 'MSD 41'.

4 CLINICAL PARTICULARS

4.1 Therapeutic Indications

Corticosteroid.

Allergic States
Severe or incapacitating allergies unresponsive to conventional treatment: seasonal or perennial allergic rhinitis, bronchial asthma, contact dermatitis, atopic dermatitis, serum sickness, drug hypersensitivity reactions.

Rheumatic disorders
As adjunctive therapy for short-term administration during an acute episode or exacerbation of: psoriatic arthritis, rheumatoid arthritis including juvenile rheumatoid arthritis (selected cases may require low-dosage maintenance therapy), ankylosing spondylitis, acute and subacute bursitis, acute non-specific tenosynovitis, acute gouty arthritis, post-traumatic osteoarthritis, synovitis of osteoarthritis, epicondylitis.

Dermatological diseases
Pemphigus, bullous dermatitis herpetiformis, severe erythema multiforme (Stevens-Johnson syndrome), exfoliative dermatitis, mycosis fungoides, severe psoriasis, severe seborrhoeic dermatitis.

Ophthalmic diseases
Severe, acute and chronic allergic and inflammatory processes involving the eye and its adnexa, such as: allergic conjunctivitis, keratitis, allergic corneal marginal ulcers, herpes zoster ophthalmicus, iritis, iridocyclitis, chorioretinitis, diffuse posterior uveitis and choroiditis, optic neuritis, sympathetic ophthalmia, anterior segment inflammation.

Endocrine disorders
Primary or secondary adrenocortical insufficiency (the first choice is hydrocortisone or cortisone, but synthetic analogues may be used with mineralocorticoids where applicable; in infancy, mineralocorticoid supplementation is particularly important), congenital adrenal hyperplasia, non-suppurative thyroiditis, hypercalcaemia associated with cancer.

Respiratory diseases
Symptomatic sarcoidosis, Loffler's syndrome not manageable by other means, berylliosis, fulminating or disseminated pulmonary tuberculosis (when accompanied by appropriate concurrent antituberculous chemotherapy), aspiration pneumonitis.

Haematological disorders
Idiopathic thrombocytopenic purpura in adults and secondary thrombocytopenia in adults, acquired (auto-immune) haemolytic anaemia, red blood cell anaemia, congenital hypoplastic anaemia.

Neoplastic diseases
Palliative management of leukaemias and lymphomas in adults, and of acute leukaemia in children.

Oedematous states
To induce a diuresis or remission of proteinuria in the nephrotic syndrome, without uraemia, of the idiopathic type due to lupus erythematosus.

Cerebral oedema
In cerebral oedema associated with primary or metastatic brain tumours; in the pre-operative preparation of patients with increased intracranial pressure secondary to brain tumours; for the palliation of symptoms in patients with inoperable or recurrent brain neoplasm; and in the management of cerebral oedema associated with neurosurgery. Some patients with cerebral oedema due to head injury or with benign intracranial hypertension (pseudotumour cerebri) may benefit from therapy with 'Decadron' Tablets. It should be used as an adjunct to, and not a replacement for, definitive management such as neurosurgery or other specific therapy.

Gastro-intestinal diseases
During a critical period of the disease in: ulcerative colitis, regional enteritis.

Other indications
Tuberculous meningitis with subarachnoid block or impending block, used concurrently with appropriate antituberculous chemotherapy; trichinosis with neurological or myocardial involvement; during an exacerbation or as maintenance therapy in some cases of systemic lupus erythematosus and acute rheumatic carditis; for diagnostic testing of adrenocortical hyperfunction.

4.2 Posology and method of administration

General considerations

Therapy is governed by the following principles:

1. Dosage should be adjusted according to the severity, prognosis and expected duration of the disease and the response of the individual patient. For infants and children, the recommended dosages will usually have to be reduced, but dosage should be governed by the severity of the condition rather than by age or bodyweight.

2. Hormone therapy is an adjunct to conventional therapy and does not replace it. Appropriate conventional therapy should be instituted as indicated.

3. If therapy is continued for more than a few days, any decrease in dosage must be *gradual*.

4. Continued supervision of the patient after cessation of corticosteroid therapy is essential, since there may be a sudden reappearance of severe manifestations of the disease for which the patient was being treated.

In acute conditions where prompt relief is urgent, high dosages are permissible and may be mandatory for a short time.

In chronic conditions requiring long-term therapy, the lowest dosage which provides adequate (but not necessarily complete) relief should be used. If a high dosage is considered essential for prolonged periods, patients should be closely observed for any signs that might indicate that a reduction in dosage or discontinuation of corticosteroid therapy is necessary. Chronic conditions are subject to periods of spontaneous remission. When such periods occur, corticosteroids should be gradually discontinued. Routine investigations, such as urine analysis, two-hour post-prandial blood sugar, determination of blood pressure and body weight, and a chest X-ray should be carried out at regular intervals if therapy is prolonged. Periodic determinations of serum potassium are advisable if high dosages are being used.

Upper gastrointestinal tract X-rays should be taken when treatment is prolonged, in patients with a history of ulcer, or when there is gastric distress. Patients may be transferred to 'Decadron' from other glucocorticoids with proper adjustment in dosage. Milligram for milligram, dexamethasone is approximately equivalent to bethamethasone, 4 to 6 times more potent than methylprednisolone and triamcinolone, 6 to 8 times more potent than prednisone and prednisolone, 25 to 30 times more potent than hydrocortisone, and about 35 times more potent than cortisone.

At equipotent anti-inflammatory doses, dexamethasone almost completely lacks the sodium-retaining property of hydrocortisone and its closely related derivatives.

Specific dosage recommendations:

In chronic, usually non-fatal diseases (e.g. endocrine and chronic rheumatic disorders, oedematous states, respiratory and gastro-intestinal diseases, some dermatological diseases and haematological disorders), therapy should be initiated with a low dosage (0.5 - 1 mg a day) which is gradually increased to the smallest amount that gives the desired degree of symptomatic relief.

When adequate suppression of symptoms is achieved, dosage should be maintained at the minimum amount capable of providing sufficient relief without excessive hormonal effects. Dosage may be administered two, three, or four times a day. Regardless of the initial daily schedule, therapy is often successful on a twice-daily regimen after the optimal maintenance dosage has been established.

In congenital adrenal hyperplasia the usual daily dose is 0.5 - 1.5 mg.

In acute, non-fatal diseases (e.g. allergic states, ophthalmic diseases, acute and subacute rheumatic disorders), the usual dosage is between 2 mg and 3 mg a day, but in some patients, higher dosages are necessary. Since these conditions are self- limiting prolonged maintenance therapy is not usually necessary.

Dual therapy
In acute, self-limiting allergic disorders or acute exacerbations of chronic allergic disorders (e.g. acute allergic rhinitis, acute attacks of seasonal allergic bronchial asthma, urticaria medicamentosa, and contact dermatoses), the following dosage schedule, which combines parenteral and oral therapy is suggested:

First day	'Decadron' Injection, 4 mg or 8 mg (1 ml or 2 ml) intramuscularly
Second day	Two 0.5 mg 'Decadron' Tablets twice a day
Third day	Two 0.5 mg 'Decadron' Tablets twice a day
Fourth day	One 0.5 mg 'Decadron' Tablet twice a day
Fifth day	One 0.5 mg 'Decadron' Tablet twice a day
Sixth day	One 0.5 mg 'Decadron' Tablet
Seventh day	One 0.5 mg 'Decadron' Tablet
Eighth day	Reassessment day

In chronic, potentially fatal diseases: such as systemic lupus erythematosus, pemphigus, symptomatic sarcoidosis, the recommended initial dosage is from 2 mg to 4.5 mg a day; higher dosages are necessary in some patients. As soon as adequate relief is obtained, the dosage should be gradually reduced to the minimum amount that will produce the desired therapeutic effect.

In acute and life-threatening diseases: (e.g. acute rheumatic carditis, crisis of systemic lupus erythematosus, severe allergic reactions, pemphigus neoplastic diseases), the initial dosage is between 4 mg and 10 mg a day, administered in at least 4 divided doses. In some patients, this dosage may have to be increased. As soon as control is attained, the dosage should be gradually reduced to the minimum that will maintain relief. When an extremely rapid onset of action is desired, 'Decadron' Injection may be administered intravenously for the first 2 or 3 doses. In severe allergic reactions, the therapy of first choice is adrenaline. 'Decadron' is useful as concurrent or supplementary therapy.

In cerebral oedema: initial therapy is usually by 'Decadron' Injection in acute conditions. When maintenance therapy

is required, this should be changed to 'Decadron' Tablets as soon as possible. For the palliative management of patients with recurrent or inoperable brain tumours, maintenance dosage should be calculated individually using 'Decadron' Injection, or 'Decadron' Tablets when oral therapy is feasible. A dosage of 2 mg two or three times a day may be effective. The smallest dosage necessary to control symptoms should always be used.

In the adrenogenital syndrome: daily dosage of 0.5 - 1.5 mg may keep children in remission and prevent the recurrence of abnormal excretion of 17-ketosteroids.

As massive therapy in certain conditions: (e.g. acute leukaemia, the nephrotic syndrome and pemphigus), the recommended dosage is 10 - 15 mg a day. Patients receiving such a high dosage should be observed very closely for the appearance of severe reactions.

Dexamethasone suppression tests

1. *Tests for Cushing's syndrome*:
Two milligrams 'Decadron' is given orally at 11 p.m., then blood is drawn for plasma cortisol determination at 8 a.m. the following morning.

For greater accuracy, 500 microgram 'Decadron' is given orally every 6 hours for 48 hours. Twenty-four-hour urine collections are made for determination of 17-hydroxycorticosteroid excretion.

2. *Test to distinguish Cushing's syndrome caused by pituitary ACTH excess from the syndrome induced by other causes*:
Two milligrams 'Decadron' is given orally every 6 hours for 48 hours. Twenty-four-hour urine collections are made for determination of 17-hydroxycorticosteroid excretion.

Use in children: Dosage should be limited to a single dose on alternate days to lessen retardation of growth and minimise suppression of hypothalamo-pituitary-adrenal axis.

Use in the elderly: Treatment of elderly patients, particularly if long term, should be planned bearing in mind the more serious consequences of the common side effects of corticosteroids in old age, especially osteoporosis, diabetes, hypertension, hypokalaemia, susceptibility to infection and thinning of the skin. Close clinical supervision is required to avoid life-threatening reactions (see 'Undesirable effects').

4.3 Contraindications

Systemic fungal infections; systemic infection unless specific anti-infective therapy is employed; hypersensitivity to any component of the drug. Administration of live virus vaccines (see 'Special warnings and special precautions for use').

4.4 Special warnings and precautions for use

The lowest dosage that will control the condition under treatment should be used. Any reduction in dosage should be made gradually.

Corticosteroids may exacerbate systemic fungal infections and should not be used in the presence of such infections unless they are needed to control life-threatening drug reactions due to amphotericin. Moreover, there have been cases reported in which concomitant use of amphotericin and hydrocortisone was followed by cardiac enlargement and heart failure.

Reports in the literature suggest an apparent association between use of corticosteroids and left-ventricular free-wall rupture after a recent myocardial infarction; therefore, corticosteroids should be used with great caution in these patients.

In cerebral malaria, the use of corticosteroids is associated with a prolonged coma and an increased incidence of pneumonia and gastro-intestinal bleeding.

Average and large doses of hydrocortisone or cortisone can cause elevation of blood pressure, retention of salt and water, and increased excretion of potassium, but these effects are less likely to occur with synthetic derivatives, except when used in large doses. Dietary salt restriction and potassium supplementation may be necessary. All corticosteroids increase calcium excretion.

In patients on corticosteroid therapy subjected to unusual stress (e.g. intercurrent illness, trauma, or surgical procedure), dosage should be increased before, during and after the stressful situation. Drug-induced secondary adrenocortical insufficiency may result from too rapid withdrawal of corticosteroids and may be minimised by gradual dosage reduction, being tapered off over weeks and/or months depending on the dose and duration of treatment, but may persist for up to a year after discontinuation of therapy. In any stressful situation during that period, therefore, corticosteroid therapy should be reinstated.

If the patient is already receiving corticosteroids, the current dosage may have to be temporarily increased. Salt and/or a mineralocorticoid should be given concurrently, since mineralocorticoid secretion may be impaired.

Following prolonged therapy, withdrawal of corticosteroids may result in acute adrenocortical insufficiency and in withdrawal symptoms including fever, myalgia, arthralgia, and malaise. This may occur in patients even without evidence of adrenal insufficiency.

Patients should carry 'steroid treatment' cards, which give clear guidance on the precautions to be taken to minimise risk, and which provide details of prescriber, drug, dosage, and the duration of treatment.

Administration of live virus vaccines is contra-indicated in individuals receiving immunosuppressive doses of corticosteroids. If inactivated viral or bacterial vaccines are administered to individuals receiving immunosuppressive doses of corticosteroids, the expected serum antibody response may not be obtained. However, patients who are receiving corticosteroids as replacement therapy, e.g. for Addison's disease may be immunised.

The use of 'Decadron' Tablets 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 an appropriate antituberculous regimen. If corticosteroids are indicated in patients with latent tuberculosis or tuberculin reactivity, close observation of the disease is necessary as reactivation may occur. During prolonged corticosteroid therapy, these patients should receive prophylactic chemotherapy.

There is an enhanced effect of corticosteroids in patients with hypothyroidism and in those with cirrhosis.

Corticosteroids may mask some signs of infection, and new infections may appear during their use. The clinical presentation may often be atypical, and serious infections such as septicaemia and tuberculosis may be masked and reach an advanced stage before being recognised. There may be decreased resistance and inability to localise infection in patients on corticosteroids.

Chickenpox is of particular concern, since this normally minor illness may be fatal in immunosuppressed patients. Patients (or parents of children) without a definite history of chickenpox should be advised to avoid close personal contact with chickenpox or herpes zoster, and if exposed they should seek urgent medical attention. Passive immunisation with varicella/zoster immunoglobulin (VZIG) is needed by exposed non-immune patients who are receiving systemic corticosteroids or who have used them within the previous three months; this should be given within ten days of exposure to chickenpox. **If a diagnosis of chickenpox is confirmed, the illness warrants specialist care and urgent treatment. Corticosteroids should not be stopped and the dose may need to be increased.**

Measles can have a more serious or even fatal course in immunosuppressed patients. In such children or adults particular care should be taken to avoid exposure to measles. If exposed, prophylaxis with intramuscular pooled immunoglobulin (IG) may be indicated. Exposed patients should be advised to seek medical advice without delay.

Corticosteroids may activate latent amoebiasis or strongyloidiasis or exacerbate active disease. Therefore, it is recommended that latent or active amoebiasis and strongyloidiasis be ruled out before initiating corticosteroid therapy in any patient at risk of or with symptoms suggestive of either condition.

Prolonged use of corticosteroids may produce subcapsular cataracts, glaucoma with possible damage to the optic nerves, and may enhance the establishment of secondary ocular infections due to fungi or viruses. Steroids may increase or decrease the motility and number of spermatozoa in some patients.

Particular care is required when considering the use of systemic corticosteroids in patients with the following conditions, and frequent patient monitoring is necessary: non-specific ulcerative colitis, if there is a probability of impending perforation abscess or other pyogenic infection, diverticulitis, fresh intestinal anastomoses; active or latent peptic ulcer; renal insufficiency; hypertension; osteoporosis; diabetes, or in those with a family history of diabetes; congestive heart failure; previous steroid myopathy; glaucoma (or family history of glaucoma); existing or previous history of severe affective disorders (especially previous steroid psychoses) liver failure; epilepsy; and myasthenia gravis. Signs of peritoneal irritation following gastro-intestinal perforation in patients receiving large doses of corticosteroids may be minimal or absent. Fat embolism has been reported as a possible complication of hypercortisonism.

Corticosteroids should be used cautiously in patients with ocular herpes simplex, because of possible corneal perforation.

Children: Corticosteroids cause growth retardation in infancy, childhood and adolescence, which may be irreversible. Treatment should be limited to the minimum dosage for the shortest possible time. In order to minimise suppression of the hypothalamo-pituitary-adrenal axis and growth retardation, treatment should be limited, where possible, to a single dose on alternate days.

Growth and development of infants and children on prolonged corticosteroid therapy should be carefully scrutinised.

4.5 Interaction with other medicinal products and other forms of interaction

‘Decadron’ should be used with caution with thalidomide, as toxic epidermal necrolysis has been reported with concomitant use of these two drugs.

Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinaemia.

The renal clearance of salicylates is increased by corticosteroids and, therefore, salicylate dosage should be reduced along with steroid withdrawal.

Dexamethasone is metabolised by cytochrome P450 3A4 (CYP 3A4). Concomitant administration of dexamethasone with cytochrome P450 3A4 enzyme inducers (e.g. phenytoin, barbiturates, rifabutin, carbamazepine and rifampicin) may enhance the metabolic clearance of corticosteroids, resulting in decreased blood levels and reduced physiological activity. This may necessitate adjustment of corticosteroid dosage. In addition, the cocomitant adminstration of dexamethasone with known inhibitors of CYP 3A4, (e.g. ketoconazole, macrolide antibiotics such as erythromycin) has the potential to result in increased plasma concentrations of dexamethasone. Effects of other drugs on the metabolism of dexamethasone may interfere with dexamethasone suppression tests, which should be interpreted with caution during administration of such drugs.

Dexamethasone is a moderate inducer of CYP 3A4. Co-administration with other drugs that are metabolised by CYP 3A4 (e.g. indinavir, erythromycin) may increase their clearance, resulting in decreased plasma concentrations.

In post-marketing experience, there have been reports of both increases and decreases in phenytoin levels with dexamethasone co-administration, leading to alterations in seizure control.

Although ketoconazole may increase dexamethasone plasma concentrations through inhibition of CYP 3A4, ketoconazole alone can inhibit adrenal corticosteroid synthesis and may cause adrenal insufficiency during corticosteroid withdrawal.

Aminoglutethimide and ephedrine may enhance metabolic clearance of corticosteroids and an increase in corticosteroid dosage may be necessary.

The prothrombin time should be checked frequently in patients who are receiving corticosteroids and coumarin anticoagulants at the same time, because of reports that corticosteroids have altered the response to these anticoagulants. Studies have shown that the usual effect produced by adding corticosteroids is inhibition of response to coumarins, although there have been some conflicting reports of potentiation not substantiated by studies.

The desired effects of hypoglycaemic agents (including insulin) are antagonised by corticosteroids.

False-negative results in the dexamethasone suppression test in patients being treated with indomethacin have been reported.

Corticosteroids may affect the nitrobluetetrazolium test for bacterial infection and produce false-negative results.

When corticosteroids are administered concomitantly with potassium-depleting diuretics, patients should be observed closely for development of hypokalaemia.

4.6 Pregnancy and lactation

Since adequate human reproduction studies have not been done with corticosteroids, their use in pregnancy, breast-feeding mothers, or women of child-bearing potential requires that the potential benefits be weighed against possible hazards to the mother and foetus or child. Infants born of mothers who have received substantial doses of corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism.

When corticosteroids are essential, however, patients with normal pregnancies may be treated as though they were in the non-gravid state. Patients with pre-eclampsia or fluid retention require close monitoring.

Corticosteroids appear in breast milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other unwanted effects. Mothers taking pharmacological doses of corticosteroids should be advised not to breast-feed.

4.7 Effects on ability to drive and use machines

There are some side effects associated with this product that may affect some patients' ability to drive or operate machinery (see 4.8 'Undesirable effects').

4.8 Undesirable effects

The incidence of predictable undesirable effects, including hypothalamic-pituitary-adrenal suppression, correlates with the relative potency of the drug, dosage, timing of administration and the duration of treatment (see 'Special warnings and special precautions for use').

Fluid and electrolyte disturbances: Sodium retention, fluid retention, congestive heart failure in susceptible patients, potassium loss, hypokalaemic alkalosis, hypertension, increased calcium excretion (see 'Special warnings and special precautions for use').

Musculoskeletal effects: Muscle weakness, steroid myopathy, loss of muscle mass, osteoporosis, vertebral compression fractures, aseptic necrosis of femoral and humeral heads, pathological fracture of long bones, tendon rupture.

Gastro-intestinal: Peptic ulcer with possible perforation and haemorrhage, perforation of the small and large bowel particularly in patients with inflammatory bowel disease, pancreatitis, abdominal distension, ulcerative oesophagitis, dyspepsia, oesophageal candidiasis.

Dermatological: Impaired wound healing, thin fragile skin, petechiae and ecchymoses, erythema, striae, telangiectasia, acne, increased sweating, suppressed reaction to skin tests, other cutaneous reactions such as allergic dermatitis, urticaria, angioneurotic oedema.

Neurological: Convulsions, vertigo, headache. Increased intracranial pressure with papilloedema (pseudotumour cerebri) may occur usually after treatment, psychic disturbances (e.g. euphoria, psychological dependence, depression, insomnia).

Endocrine: Menstrual irregularities, amenorrhoea, development of Cushingoid state, suppression of growth in children and adolescents, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress as in trauma, surgery or illness), decreased carbohydrate tolerance, manifestations of latent diabetes mellitus, hyperglycaemia, increased requirements for insulin or oral hypoglycaemic agents in diabetics, hirsutism.

Anti-inflammatory and immunosuppressive effects: Increased susceptibility and severity of infections with suppression of clinical symptoms and signs. Opportunistic infections, recurrence of dormant tuberculosis (see 'Special warnings and special precautions for use').

Ophthalmic: Posterior subcapsular cataracts, increased intra-ocular pressure, papilloedema, corneal or scleral thinning, exacerbation of ophthalmic viral disease, glaucoma, exophthalmos.

Metabolic: Negative nitrogen balance due to protein catabolism. Negative calcium balance.

Cardiovascular: Myocardial rupture following recent myocardial infarction (see 'Special warnings and special precautions for use').

Other: Hypersensitivity, thrombo-embolism, weight gain, increased appetite, nausea, malaise, hiccups.

Withdrawal symptoms and signs: Too rapid a reduction of corticosteroid dosage following prolonged treatment can lead to acute adrenal insufficiency, hypotension, and death (see 'Special warnings and special precautions for use').

In some instances, withdrawal symptoms may simulate a clinical relapse of the disease for which the patient has been undergoing treatment.

4.9 Overdose

Anaphylactic and hypersensitivity reactions may be treated with epinephrine (adrenaline), positive-pressure artificial respiration and aminophylline. The patient should be kept warm and quiet. Treatment is probably not indicated for reactions due to chronic poisoning unless the patient has a condition that would render him unusually susceptible to ill effects from corticosteroids. In this case, the stomach should be emptied and symptomatic treatment should be instituted as necessary.

5 PHARMACOLOGICAL PROPERTIES

5.1 Pharmacodynamic properties

Dexamethasone is a glucocorticoid. It possesses the actions and effects of other basic glucocorticoids, and is among the most active members. Glucocorticoids are adrenocortical steroids, both naturally occurring and synthetic, which are readily absorbed from the gastro-intestinal tract. They cause profound and varied metabolic effects and in addition they modify the body's immune responses to diverse stimuli.

Naturally occurring glucocorticoids (hydrocortisone and cortisone), which also have salt-retaining properties, are used as replacement therapy in adrenocortical deficiency states. Their synthetic analogs, including dexamethasone, are used primarily for their potent anti-inflammatory effects in disorders of many organ systems.

5.2 Pharmacokinetic properties

Dexamethasone is readily absorbed from the gastro-intestinal tract.

Its biological half-life in plasma is about 190 minutes.

Binding of dexamethasone to plasma proteins is less than for most other corticosteroids and is estimated to be about 77%.

Up to 65% of a dose is excreted in the urine in 24 hours, the rate of excretion being increased following concomitant administration of phenytoin.
The more potent halogenated corticosteroids such as dexamethasone, appear to cross the placental barrier with minimal inactivation.

Dexamethasone has predominant glucocorticoid activity with little propensity to promote renal retention of sodium and water. Therefore, it does not offer complete replacement therapy, and must be supplemented with salt and/or deoxycorticosterone. Cortisone and hydrocortisone also act predominately as glucocorticoids, although their mineralocorticoid action is greater than that of dexamethasone. Their use in patients with total adrenocortical insufficiency also may require supplemental salt, deoxycortisone, or both.

5.3 Preclinical safety data

No relevant information.

6 PHARMACEUTICAL PARTICULARS

6.1 List of excipients

Calcium hydrogen phosphate E341
Lactose
Magnesium stearate E572
Maize Starch
Purified Water

6.2 Incompatibilities

Not applicable.

6.3 Shelf Life

1 year.

6.4 Special precautions for storage

Do not store above 25^{o}C.

Store in the original package.

6.5 Nature and contents of container

Opaque PVC blister lidded with aluminium foil, containing 30 tablets.

6.6 Special precautions for disposal of a used medicinal product or waste materials derived from such medicinal product and other handling of the product

No special requirements.

7 MARKETING AUTHORISATION HOLDER

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