

Aristocort®
(Triamcinolone Diacetate, USP) Injectable Suspension

25 mg/mL PARENTERAL

NOT FOR USE IN NEONATES

NOT FOR INTRAVENOUS USE

CONTAINS BENZYL ALCOHOL

DESCRIPTION

Aristocort® is a sterile suspension of 25 mg/mL of triamcinolone diacetate (micronized) suspended in a vehicle consisting of:

Polysorbate 80	0.20%
Polyethylene Glycol	3%
Sodium Chloride	0.85%
Benzyl Alcohol	0.90%
Water for Injection q.s.	100%

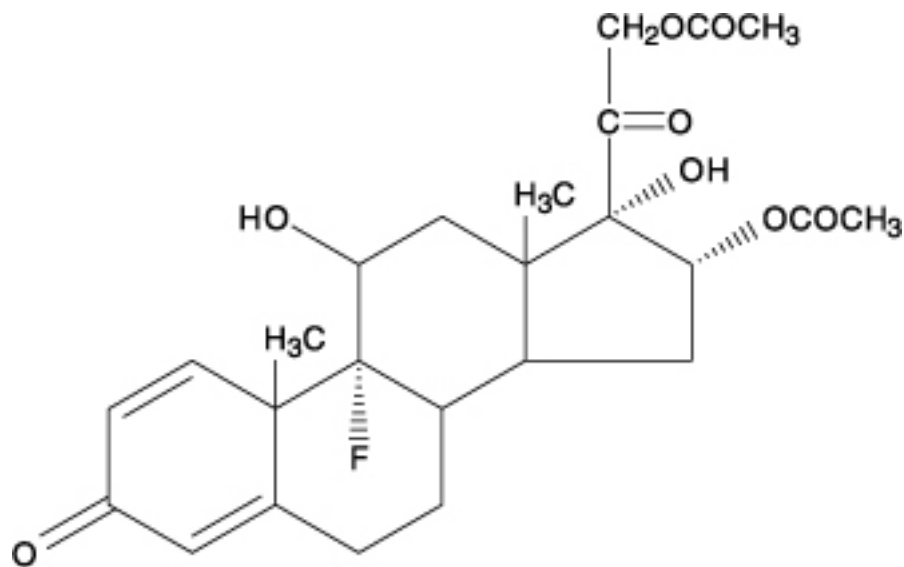
Hydrochloric acid and/or sodium hydroxide may be used during manufacture to adjust pH of suspension to approximately 6.

Triamcinolone diacetate is practically insoluble in water; soluble in chloroform; sparingly soluble in alcohol and in methanol; and slightly soluble in ether. This preparation is suitable for parenteral administration through a 23-gauge needle (or larger), but NOT suitable for intravenous use. It may be administered by the intramuscular, intra-articular, or intrasynovial routes, depending upon the situation.

Irreversible clumping occurs when this product is frozen.

Chemically triamcinolone diacetate is 9-fluoro-11 β ,16 α ,17,21-tetrahydroxypregna-1,4-diene-3,20-dione 16,21-diacetate.

The molecular weight is 478.51. Its structural formula is:



Triamcinolone diacetate occurs as a white to off-white, microcrystalline powder.

CLINICAL PHARMACOLOGY

Glucocorticoids, naturally occurring and synthetic, are adrenocortical steroids that are readily adsorbed from the gastrointestinal tract.

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

Triamcinolone diacetate is essentially devoid of mineralocorticoid activity when administered in therapeutic doses, causing little or no sodium retention with potassium excretion minimal or absent.

INDICATIONS AND USAGE

Where oral therapy is not feasible, Aristocort® (triamcinolone diacetate injectable suspension), 25 mg/mL, is indicated for intramuscular use as follows:

Allergic States

Control of severe or incapacitating allergic conditions intractable to adequate trials of conventional treatment in asthma, atopic dermatitis, contact dermatitis, drug hypersensitivity reactions, perennial or seasonal allergic rhinitis, serum sickness, transfusion reactions.

Dermatologic Diseases

Bullous dermatitis herpetiformis, exfoliative erythroderma, mycosis fungoides, pemphigus, severe erythema multiforme (Stevens-Johnson syndrome).

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), congenital adrenal hyperplasia, hypercalcemia associated with cancer, nonsuppurative thyroiditis.

Gastrointestinal Disease

To tide the patient over a critical period of the disease in regional enteritis and ulcerative colitis.

Hematologic Disorders

Acquired (autoimmune) hemolytic anemia, Diamond-Blackfan anemia, pure red cell aplasia, selected cases of secondary thrombocytopenia.

Miscellaneous

Trichinosis with neurologic or myocardial involvement, tuberculous meningitis with subarachnoid block or impending block when used with appropriate antituberculous chemotherapy.

Neoplastic Diseases

For palliative management of leukemias and lymphomas.

Nervous System

Acute exacerbations of multiple sclerosis; cerebral edema associated with primary or metastatic brain tumor, or craniotomy.

Ophthalmic Diseases

Sympathetic ophthalmia, uveitis and ocular inflammatory conditions unresponsive to topical corticosteroids.

Renal Diseases

To induce diuresis or remission of proteinuria in idiopathic nephrotic syndrome or that due to lupus erythematosus.

Respiratory Diseases

Berylliosis, fulminating or disseminated pulmonary tuberculosis when used concurrently with appropriate antituberculous chemotherapy, idiopathic eosinophilic pneumonias, symptomatic sarcoidosis.

Rheumatic Disorders

As adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in acute gouty arthritis; acute rheumatic carditis; ankylosing spondylitis; psoriatic

arthritis; rheumatoid arthritis, including juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy). For the treatment of dermatomyositis, polymyositis, and systemic lupus erythematosus.

For Intra-Articular or Soft Tissue Administration

The intra-articular or soft tissue administration of Aristocort® is indicated as adjunctive therapy for short-term administration (to tide the patient over an acute episode or exacerbation) in acute gouty arthritis, acute and subacute bursitis, acute nonspecific tenosynovitis, epicondylitis, rheumatoid arthritis, synovitis of osteoarthritis.

For Intralesional Administration

The intralesional administration of Aristocort® is indicated for alopecia areata; discoid lupus erythematosus; keloids; localized hypertrophic, infiltrated, inflammatory lesions of granuloma annulare, lichen planus, lichen simplex chronicus (neurodermatitis), and psoriatic plaques; necrobiosis lipoidica diabetorum.

It may also be useful in cystic tumors of an aponeurosis or tendon (ganglia).

CONTRAINDICATIONS

Aristocort® is contraindicated in patients who are hypersensitive to any components of this product.

Intramuscular corticosteroid preparations are contraindicated for idiopathic thrombocytopenic purpura.

Aristocort® is contraindicated for intrathecal administration. Reports of severe medical events have been associated with this route of administration.

Aristocort is contraindicated for use in premature infants because the formulation contains benzyl alcohol (see [WARNINGS](#) and [PRECAUTIONS: Pediatric Use](#)).

Aristocort is contraindicated in systemic fungal infections, except when administered as an intra-articular injection for localized joint conditions (see [WARNINGS: Infections:Fungal Infections](#)).

WARNINGS

Serious Neurologic Adverse Reactions with Epidural Administration

Serious neurologic events, some resulting in death, have been reported with epidural injection of corticosteroids. Specific events reported include, but are not limited to, spinal cord infarction, paraplegia, quadriplegia, cortical blindness, and stroke. These serious neurologic events have been reported with and without use of fluoroscopy. The safety and effectiveness of epidural administration of corticosteroids have not been established, and corticosteroids are not approved for this use.

General

This product contains benzyl alcohol which is potentially toxic when administered locally to neural tissue. Exposure to excessive amounts of benzyl alcohol has been associated with toxicity (hypotension, metabolic acidosis), particularly in neonates, and an increased incidence of kernicterus, particularly in small preterm infants. There have been rare reports of deaths, primarily in preterm infants, associated with exposure to excessive amounts of benzyl alcohol. Administration of high dosages of medications containing this preservative must take into account the total amount of benzyl alcohol administered. The amount of benzyl alcohol at which toxicity may occur is not known. If the patient requires more than the recommended dosages or other medications containing this preservative, the practitioner must consider the daily metabolic load of benzyl alcohol from these combined sources (see [PRECAUTIONS: Pediatric Use](#)).

It is critical that, during administration of Aristocort®, appropriate technique be used and care taken to assure proper placement of drug.

Rare instances of anaphylactoid reactions have occurred in patients receiving corticosteroid therapy (see [ADVERSE REACTIONS](#)).

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

Results from one multicenter, randomized, placebo controlled study with methylprednisolone hemisuccinate, an IV corticosteroid, showed an increase in early (at 2 weeks) and late (at 6 months) mortality in patients with cranial trauma who were determined not to have other clear indications for corticosteroid treatment. High doses of systemic corticosteroids, including Aristocort®, should not be used for the treatment of traumatic brain injury.

Cardio-renal

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

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

Endocrine

Corticosteroids can produce reversible hypothalamic-pituitary adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency after withdrawal of treatment. Drug induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstated.

Metabolic clearance of corticosteroids is decreased in hypothyroid patients and increased in hyperthyroid patients. Changes in thyroid status of the patient may necessitate adjustment in dosage.

Infections

General

Patients who are on corticosteroids are more susceptible to infections than are healthy individuals. There may be decreased resistance and inability to localize infection when corticosteroids are used. Infection with any pathogen (viral, bacterial, fungal, protozoan or helminthic) in any location of the body may be associated with the use of corticosteroids alone or in combination with other immunosuppressive agents. 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. Corticosteroids may also mask some signs of current infection.

Fungal Infections

Corticosteroids may exacerbate systemic fungal infections and therefore should not be used in the presence of such infections unless they are needed to control drug reactions. There have been cases reported in which concomitant uses of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure (see [PRECAUTIONS: Drug Interactions: Amphotericin B Injection and Potassium-Depleting Agents](#)).

Special Pathogens

Latent disease may be activated or there may be an exacerbation of intercurrent infections due to pathogens, including those caused by Amoeba, Candida, Cryptococcus, Mycobacterium, Nocardia, Pneumocystis, Toxoplasma.

It is recommended that latent amebiasis or active amebiasis be ruled out before initiating corticosteroid therapy in any patient who has spent time in the tropics or in any patient with unexplained diarrhea.

Similarly, corticosteroids should be used with great care in patients with known or suspected *Strongyloides* (threadworm) infestation. In such patients, corticosteroid-induced immunosuppression may lead to *Strongyloides* hyperinfection and dissemination with widespread larval migration, often accompanied by severe enterocolitis and potentially fatal gram-negative septicemia.

Corticosteroids should not be used in cerebral malaria.

Tuberculosis

The use of corticosteroids 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 is necessary as reactivation of the disease may occur. During prolonged corticosteroid therapy, these patients should receive chemoprophylaxis.

Vaccination

Administration of live or live, attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids. Killed or inactivated vaccines may be administered. However, the response to such vaccines can not be predicted. Immunization procedures may be undertaken in patients who are receiving corticosteroids as replacement therapy, e.g., for Addison's disease.

Viral Infections

Chicken pox and measles can have a more serious or even fatal course in pediatric and adult patients on corticosteroids. In pediatric and adult patients who have not had these diseases, particular care should be taken to avoid exposure. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chicken pox, prophylaxis with varicella zoster immune globulin (VZIG) may be indicated. If exposed to measles, prophylaxis with immunoglobulin (IG) may be indicated. (See the respective package inserts for complete VZIG and IG prescribing information.) If chicken pox develops, treatment with antiviral agents should be considered.

Neurologic

Reports of severe adverse reactions have been associated with the intrathecal route of administration (see [ADVERSE REACTIONS: Neurologic/Psychiatric](#)).

Ophthalmic

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 bacteria, fungi, or viruses. The use of systemic corticosteroids is not recommended in the treatment of optic neuritis and may lead to an increase in the risk of new episodes. Corticosteroids should be used cautiously in patients with ocular herpes simplex because of possible corneal perforation. Corticosteroids should not be used in active ocular herpes simplex.

PRECAUTIONS

General

This product, like many other steroid formulations, is sensitive to heat. Therefore, it should not be autoclaved when it is desirable to sterilize the exterior of the vial.

The lowest possible dose of corticosteroid should be used to control the condition under treatment. When reduction in dosage is possible, the reduction should be gradual.

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 and as to whether daily or intermittent therapy should be used.

Kaposi's sarcoma has been reported to occur in patients receiving corticosteroid therapy, most often for chronic conditions. Discontinuation of corticosteroids may result in clinical improvement.

Atrophy at the site of injection has been reported.

Cardio-renal

As sodium retention with resultant edema and potassium loss may occur in patients receiving corticosteroids, these agents should be used with caution in patients with congestive heart failure, hypertension, or renal insufficiency.

Endocrine

Drug-induced secondary adrenocortical insufficiency may be minimized by gradual reduction of dosage. This type of relative insufficiency may persist for months after discontinuation of therapy; therefore, in any situation of stress occurring during that period, hormone therapy should be reinstated. Since mineralocorticoid secretion may be impaired, salt and/or a mineralocorticoid should be administered concurrently.

Gastrointestinal

Steroids should be used with caution in active or latent peptic ulcer, diverticulitis, fresh intestinal anastomoses, and nonspecific ulcerative colitis, since they may increase the risk of a perforation.

Signs of peritoneal irritation following gastrointestinal perforation in patients receiving corticosteroids may be minimal or absent.

There is an enhanced effect due to increased metabolism of corticosteroids in patients with cirrhosis.

Intra-Articular and Soft Tissue Administration

Intra-articularly injected corticosteroids may be systemically absorbed.

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.

Injection of a steroid into an infected site is to be avoided. Local injection of a steroid into a previously infected joint is not usually recommended.

Musculoskeletal

Corticosteroids decrease bone formation and increase bone resorption both through their effect on calcium regulation (i.e., decreasing absorption and increasing excretion) and inhibition of osteoblast function. This, together with a decrease in the protein matrix of the bone secondary to an increase in protein catabolism, and reduced sex hormone production, may lead to inhibition of bone growth in pediatric patients and the development of osteoporosis at any age. Special consideration should be given to patients at increased risk of osteoporosis (i.e., postmenopausal women) before initiating corticosteroid therapy.

Neurologic/Psychiatric

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 they 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 [DOSAGE AND ADMINISTRATION](#).)

An acute myopathy has been observed with the use of high doses of corticosteroids, most often occurring in patients with disorders of neuromuscular transmission (e.g., myasthenia gravis), or in

patients receiving concomitant therapy with neuromuscular blocking drugs (e.g., pancuronium). This acute myopathy is generalized, may involve ocular and respiratory muscles, and may result in quadriplegia. Elevation of creatinine kinase may occur. Clinical improvement or recovery after stopping corticosteroids may require weeks to years.

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.

Ophthalmic

Intraocular pressure may become elevated in some individuals. If steroid therapy is continued for more than 6 weeks, intraocular pressure should be monitored.

Information for Patients

Patients should be warned not to discontinue the use of corticosteroids abruptly or without medical supervision, to advise any medical attendants that they are taking corticosteroids and to seek medical advice at once should they develop fever or other signs of infection.

Persons who are on corticosteroids should be warned to avoid exposure to chicken pox or measles. Patients should also be advised that if they are exposed, medical advice should be sought without delay.

Drug Interactions

Aminoglutethimide

Aminoglutethimide may lead to a loss of corticosteroid-induced adrenal suppression.

Amphotericin B Injection and Potassium-Depleting Agents

When corticosteroids are administered concomitantly with potassium-depleting agents (i.e., amphotericin B, diuretics), patients should be observed closely for development of hypokalemia. There have been cases reported in which concomitant use of amphotericin B and hydrocortisone was followed by cardiac enlargement and congestive heart failure.

Antibiotics

Macrolide antibiotics have been reported to cause a significant decrease in corticosteroid clearance (see [Drug Interactions: Hepatic Enzyme Inhibitors](#)).

Anticholinesterases

Concomitant use of anticholinesterase agents and corticosteroids may produce severe weakness in patients with myasthenia gravis. If possible, anticholinesterase agents should be withdrawn at least 24 hours before initiating corticosteroid therapy.

Anticoagulants, Oral

Coadministration of corticosteroids and warfarin usually results in inhibition of response to warfarin, although there have been some conflicting reports. Therefore, coagulation indices should be monitored frequently to maintain the desired anticoagulant effect.

Antidiabetics

Because corticosteroids may increase blood glucose concentrations, dosage adjustments of antidiabetic agents may be required.

Antitubercular Drugs

Serum concentrations of isoniazid may be decreased.

Cholestyramine

Cholestyramine may increase the clearance of corticosteroids.

Cyclosporine

Increased activity of both cyclosporine and corticosteroids may occur when the two are used concurrently. Convulsions have been reported with this concurrent use.

Digitalis Glycosides

Patients on digitalis glycosides may be at increased risk of arrhythmias due to hypokalemia.

Estrogens, including Oral Contraceptives

Estrogens may decrease the hepatic metabolism of certain corticosteroids, thereby increasing their effect.

Hepatic Enzyme Inducers (e.g., Barbiturates, Phenytoin, Carbamazepine, Rifampin)

Drugs which induce cytochrome P450 3A4 enzyme activity may enhance the metabolism of corticosteroids and require that the dosage of the corticosteroid be increased.

Hepatic Enzyme Inhibitors (e.g., ketoconazole, macrolide antibiotics such as erythromycin and troleandomycin)

Drugs which inhibit cytochrome P450 3A4 enzyme activity have the potential to result in increased plasma concentrations of corticosteroids.

Ketoconazole

Ketoconazole has been reported to significantly decrease the metabolism of certain corticosteroids by up to 60%, leading to an increased risk of corticosteroid side effects.

Nonsteroidal Anti-Inflammatory Agents (NSAIDs)

Concomitant use of aspirin (or other nonsteroidal anti-inflammatory agents) and corticosteroids increases the risk of gastrointestinal side effects. Aspirin should be used cautiously in conjunction with corticosteroids in hypoprothrombinemia. The clearance of salicylates may be increased with concurrent use of corticosteroids.

Skin Tests

Corticosteroids may suppress reactions to skin tests.

Vaccines

Patients on prolonged corticosteroid therapy may exhibit a diminished response to toxoids and live or inactivated vaccines due to inhibition of antibody response. Corticosteroids may also potentiate the replication of some organisms contained in live attenuated vaccines. Routine administration of vaccines or toxoids should be deferred until corticosteroid therapy is discontinued if possible (see [WARNINGS: Vaccination](#)).

Carcinogenesis, Mutagenesis, Impairment of Fertility

No adequate studies have been conducted in animals to determine whether corticosteroids have a potential for carcinogenesis or mutagenesis.

Steroids may increase or decrease motility and number of spermatozoa in some patients.

Pregnancy

Teratogenic Effects

Pregnancy Category C

Corticosteroids have been shown to be teratogenic in many species when given in doses equivalent to the human dose. Animal studies in which corticosteroids have been given to pregnant mice, rats, and rabbits have yielded an increased incidence of cleft palate in the offspring. There are no adequate and well-controlled studies in pregnant women. Corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Infants born to mothers who have received corticosteroids during pregnancy should be carefully observed for signs of hypoadrenalism.

Nursing Mothers

Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. Because of the potential for serious adverse reactions in nursing infants from corticosteroids, a decision should be made whether to continue nursing, or discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

This product contains benzyl alcohol as a preservative. Benzyl alcohol, a component of this product, has been associated with serious adverse events and death, particularly in pediatric patients. The “gaspings syndrome,” (characterized by central nervous system depression, metabolic acidosis, gasping respirations, and high levels of benzyl alcohol and its metabolites found in the blood and urine) has been associated with benzyl alcohol dosages >99 mg/kg/day in neonates and low-birth-weight neonates. Additional symptoms may include gradual neurological

deterioration, seizures, intracranial hemorrhage, hematologic abnormalities, skin breakdown, hepatic and renal failure, hypotension, bradycardia, and cardiovascular collapse. Although normal therapeutic doses of this product deliver amounts of benzyl alcohol that are substantially lower than those reported in association with the “gaspings syndrome,” the minimum amount of benzyl alcohol at which toxicity may occur is not known. Premature and low-birth-weight infants, as well as patients receiving high dosages, may be more likely to develop toxicity. Practitioners administering this and other medications containing benzyl alcohol should consider the combined daily metabolic load of benzyl alcohol from all sources.

The efficacy and safety of corticosteroids in the pediatric population are based on the well-established course of effect of corticosteroids which is similar in pediatric and adult populations. Published studies provide evidence of efficacy and safety in pediatric patients for the treatment of nephrotic syndrome (>2 years of age), and aggressive lymphomas and leukemias (>1 month of age). Other indications for pediatric use of corticosteroids, e.g., severe asthma and wheezing, are based on adequate and well-controlled trials conducted in adults, on the premises that the course of the diseases and their pathophysiology are considered to be substantially similar in both populations.

The adverse effects of corticosteroids in pediatric patients are similar to those in adults (see [ADVERSE REACTIONS](#)). Like adults, pediatric patients should be carefully observed with frequent measurements of blood pressure, weight, height, intraocular pressure, and clinical evaluation for the presence of infection, psychosocial disturbances, thromboembolism, peptic ulcers, cataracts, and osteoporosis. Pediatric patients who are treated with corticosteroids by any route, including systemically administered corticosteroids, may experience a decrease in their growth velocity. This negative impact of corticosteroids on growth has been observed at low systemic doses and in the absence of laboratory evidence of HPA axis suppression (i.e., cosyntropin stimulation and basal cortisol plasma levels). Growth velocity may therefore be a more sensitive indicator of systemic corticosteroid exposure in pediatric patients than some commonly used tests of HPA axis function. The linear growth of pediatric patients treated with corticosteroids should be monitored, and the potential growth effects of prolonged treatment should be weighed against clinical benefits obtained and the availability of treatment alternatives. In order to minimize the potential growth effects of corticosteroids, pediatric patients should be *titrated* to the lowest effective dose.

Geriatric Use

Clinical studies did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

ADVERSE REACTIONS

(listed alphabetically, under each subsection)

Allergic Reactions

Allergic or hypersensitivity reactions, anaphylactoid reactions, anaphylaxis, angioedema.

Cardiovascular

Bradycardia, cardiac arrest, cardiac arrhythmias, cardiac enlargement, circulatory collapse, congestive heart failure, fat embolism, hypertension, hypertrophic cardiomyopathy in premature infants, myocardial rupture following recent myocardial infarction (see [WARNINGS](#)), pulmonary edema, syncope, tachycardia, thromboembolism, thrombophlebitis, vasculitis.

Dermatologic

Acne, allergic dermatitis, cutaneous and subcutaneous atrophy, dry scaly skin, ecchymoses and petechiae, edema, erythema, hyperpigmentation, hypopigmentation, impaired wound healing, increased sweating, rash, sterile abscess, striae, suppressed reactions to skin tests, thin fragile skin, thinning scalp hair, urticaria.

Endocrine

Decreased carbohydrate and glucose tolerance, development of cushingoid state, glycosuria, hirsutism, hypertrichosis, increased requirements for insulin or oral hypoglycemic agents in diabetes, manifestations of latent diabetes mellitus, menstrual irregularities, secondary adrenocortical and pituitary unresponsiveness (particularly in times of stress, as in trauma, surgery, or illness), suppression of growth in pediatric patients.

Fluid and Electrolyte Disturbances

Congestive heart failure in susceptible patients, fluid retention, hypokalemic alkalosis, potassium loss, sodium retention.

Gastrointestinal

Abdominal distention, bowel/bladder dysfunction (after intrathecal administration), elevation in serum liver enzyme levels (usually reversible upon discontinuation), hepatomegaly, increased appetite, nausea, pancreatitis, peptic ulcer with possible perforation and hemorrhage, perforation of the small and large intestine (particularly in patients with inflammatory bowel disease), ulcerative esophagitis.

Metabolic

Negative nitrogen balance due to protein catabolism.

Musculoskeletal

Aseptic necrosis of femoral and humeral heads, calcinosis (following intra-articular or intralesional use), Charcot-like arthropathy, loss of muscle mass, muscle weakness, osteoporosis, pathologic fracture of long bones, postinjection flare (following intra-articular use), steroid myopathy, tendon rupture, vertebral compression fractures.

Neurologic/Psychiatric

Convulsions, depression, emotional instability, euphoria, headache, increased intracranial pressure with papilledema (pseudotumor cerebri) usually following discontinuation of treatment, insomnia, mood swings, neuritis, neuropathy, paresthesia, personality changes, psychic disorders, vertigo. Arachnoiditis, meningitis, paraparesis/paraplegia, and sensory disturbances have occurred after intrathecal administration (see [WARNINGS: Neurologic](#)).

Ophthalmic

Exophthalmos, glaucoma, increased intraocular pressure, posterior subcapsular cataracts, rare instances of blindness associated with periocular injections.

Other

Abnormal fat deposits, decreased resistance to infection, hiccups, increased or decreased motility and number of spermatozoa, injection site infections following non-sterile administration (see [WARNINGS](#)), malaise, moon face, weight gain.

OVERDOSAGE

Treatment of acute overdosage is by supportive and symptomatic therapy. For chronic overdosage in the face of severe disease requiring continuous steroid therapy, the dosage of the corticosteroid may be reduced only temporarily, or alternate day treatment may be introduced.

DOSAGE AND ADMINISTRATION

NOTE: CONTAINS BENZYL ALCOHOL (see [WARNINGS](#) and [PRECAUTIONS: Pediatric Use](#))

Because of possible physical incompatibilities, Aristocort® Sterile Aqueous Suspension should not be diluted or mixed with other solutions.

General

The initial intramuscular dosage of triamcinolone diacetate injectable suspension may vary from 3 to 48 mg per day depending on the specific disease entity being treated. However, in certain overwhelming, acute, life-threatening situations, administration in dosages exceeding the usual dosages may be justified and may be in multiples of the oral dosages.

It Should be Emphasized that Dosage Requirements are Variable and Must be Individualized on the Basis of the Disease Under Treatment and the Response of the Patient. After a favorable response is noted, the proper maintenance dosage should be determined by decreasing the initial drug dosage in small decrements at appropriate time intervals until the lowest dosage which will maintain an adequate clinical response is reached. Situations which may make dosage adjustments necessary are changes in clinical status secondary to remissions or exacerbations in the disease process, the patient's individual drug responsiveness, and the effect of patient exposure to stressful situations not directly related to the disease entity under treatment. In this latter situation it may be necessary to increase the dosage of the corticosteroid for a period of time consistent with the patient's condition. If after long-term therapy the drug is to be stopped, it is recommended that it be withdrawn gradually rather than abruptly.

In the treatment of acute exacerbations of multiple sclerosis, daily doses of 160 mg of triamcinolone for a week followed by 64 mg every other day for one month are recommended (see [PRECAUTIONS: Neurologic/Psychiatric](#)).

In pediatric patients, the initial dose of triamcinolone may vary depending on the specific disease entity being treated. The range of initial doses is 0.11 to 1.6 mg/kg/day in three or four divided doses (3.2 to 48 mg/m² bsa/day).

For the purpose of comparison, the following is the equivalent milligram dosage of the various glucocorticoids:

<i>Betamethasone, 0.75</i>	<i>Methylprednisolone, 4</i>
<i>Cortisone, 25</i>	<i>Paramethasone, 2</i>
<i>Dexamethasone, 0.75</i>	<i>Prednisolone, 5</i>
<i>Hydrocortisone, 20</i>	<i>Triamcinolone, 4</i>

These dose relationships apply only to oral or intravenous administration of these compounds. When these substances or their derivatives are injected intramuscularly or into joint spaces, their relative properties may be greatly altered.

Specific

Aristocort® Parenteral is triamcinolone diacetate injectable suspension (25 mg/mL) suspended in a suitable vehicle. The full-strength suspension may be employed. Topical ethyl chloride spray may be used locally prior to injection.

Since this product has been designed for ease of administration, a small bore needle (not smaller than 23 gauge) may be used.

Intramuscular

Although Aristocort® Parenteral may be administered intramuscularly for initial therapy, most physicians prefer to adjust the dose orally until adequate control is attained. Intramuscular administration provides a sustained or depot action which can be used to supplement or replace initial oral therapy. With intramuscular therapy, greater supervision of the amount of steroid used is made possible in the patient who is inconsistent in following an oral dosage schedule. In maintenance therapy, the patient-to-patient response is not uniform and, therefore, the dose must be individualized for optimal control.

The average dose is 25mg (1 mL) administered intramuscularly once a week for conditions in which anti-inflammatory action is desired.

In general, a single parenteral dose 4 to 7 times the oral daily dose may be expected to control the patient from 4 to 7 days up to 3 to 4 weeks. Dosage should be adjusted to the point where adequate but not necessarily complete relief of symptoms is obtained.

Intra-Articular and Intrasynovial

The usual dose varies from 5 to 40 mg. The average for the knee, for example, is 25 mg. The duration of effect varies from one week to 2 months. However, acutely inflamed joints may require more frequent injections.

A lesser initial dosage range of triamcinolone diacetate injectable suspension may produce the desired effect when the drug is administered to provide a localized concentration. The site of the

injection and the volume of the injection should be carefully considered when triamcinolone diacetate is administered for this purpose.

A specific dose depends largely on the size of the joint.

Strict surgical asepsis is mandatory. The physician should be familiar with anatomical relationships as described in standard textbooks. Aristocort® Parenteral may be used in any accessible joint except the intervertebrals. In general, intrasynovial therapy is suggested under the following circumstances:

1. When systemic steroid therapy is contraindicated because of side effects such as peptic ulcer.
2. When it is desirable to secure relief in one or two specific joints.
3. When good systemic maintenance fails to control flare-ups in a few joints, and it is desirable to secure relief without increasing oral therapy.

Such treatment should not be considered to constitute a cure, for although this method will ameliorate the joint symptoms, it does not preclude the need for the conventional measures usually employed.

It is suggested that infiltration of the soft tissue by local anesthetic precede intra-articular injection. A 24-gauge or larger needle on a dry syringe may be inserted into the joint and excess fluid aspirated. For the first few hours following injection, there may be local discomfort in the joint but this is usually followed rapidly by effective relief of pain and improvement in local function.

HOW SUPPLIED

Aristocort® (triamcinolone diacetate injectable suspension), 25 mg/mL, parenteral, Not For Intravenous Use, supplied as follows:

NDC 0781-3036-75 25 mg/mL (5 mL Fill in a 10 mL Vial), boxes of 1

Protect from light.

DO NOT FREEZE

SHAKE WELL

Store at 20°-25°C (68°-77°F) [see USP Controlled Room Temperature].

Irreversible clumping occurs when product is frozen.

04-2014M

U100XXXX

Manufactured in Canada by

Sandoz Canada Inc. for

Sandoz Inc., Princeton, NJ 08540