MADISON NEUROLOGY LLC

608 403 0000

*Neurology Care 7 days a Week. Because Your Brain Matters.*

# Solu-Medrol®

## Methylprednisolone sodium succinate (IV)

COMPLETE CLINICAL PROTOCOL: PRE-TREATMENT CHECKLIST • ORDER SET • FOLLOW-UP • HOLD/DISCONTINUE CRITERIA

| | |
|---|---|
| **GENERIC NAME** | methylprednisolone sodium succinate (IV) |
| **BRAND** | SOLU-MEDROL® |
| **MEDICATION CLASS** | High-dose IV corticosteroid |
| **PRESENTATION** | 40 mg, 125 mg, 500 mg, and 1,000 mg vials for reconstitution |
| **ROUTE** | IV infusion over 30–60 minutes (never rapid IV push — arrhythmia/arrest reported with rapid high-dose administration) |
| **US INDICATION (FDA)** | Acute neuroinflammatory exacerbations: MS relapse, optic neuritis, NMOSD attack, acute transverse myelitis, and similar flares. |

**Class context.**
High-dose IV steroids accelerate relapse recovery; they do not modify disease course and do not substitute for DMT decisions. For optic neuritis, the evidence base supports IV methylprednisolone (± oral taper) — NOT oral prednisone alone at conventional doses.

## Section 1 — Pre-Treatment Checklist

### A. Required screening labs

☐ PSEUDORELAPSE screen FIRST — urinalysis, temperature, respiratory review: infection (especially UTI) is the commonest mimic of an MS relapse and steroids given into untreated infection worsen both. Treat infection first; reassess.

☐ Baseline glucose and potassium — hyperglycemia and hypokalemia are the common metabolic effects; diabetics need a short-term intensified monitoring plan.

☐ Blood pressure baseline and each treatment day.

- ☐ History review: diabetes, peptic ulcer/GI bleeding, glaucoma, cataracts, psychiatric history (steroid psychosis/mania), severe osteoporosis, prior steroid intolerance.
- ☐ Pregnancy test when relevant — not absolutely contraindicated, but requires risk-benefit review.

### B. Vaccinations

- ☐ Avoid live vaccines during high-dose courses and for an interval afterward per immunization guidance.

### C. Clinical assessments & counseling

- ☐ Document the neurologic deficit and a severity score BEFORE treatment — the baseline defines 'response' at follow-up.
- ☐ Define the treatment goal and the escalation plan if response is inadequate (e.g., NMOSD: plasma exchange).

### D. Exclusion / hold criteria — do not start

| CRITERION | RATIONALE / REQUIRED ACTION |
|---|---|
| Systemic fungal infection or untreated serious infection | Treat infection first; steroids into active infection are hazardous. |
| Known hypersensitivity to the formulation | Do not administer. |
| Uncontrolled diabetes or hypertensive urgency | Stabilize first, or treat with intensified monitoring and specialist input. |

## Section 2 — Order Set

### Premedication

- ☐ None required. Optional: H2-blocker or PPI for ulcer-risk patients; antiemetic rarely needed.

### Dosing schedule

| | |
|---|---|
| **MS relapse / optic neuritis** | Methylprednisolone 1,000 mg IV once daily × 3–5 days, infused over 30–60 minutes (some centers use 500 mg × 5 days). |
| **NMOSD acute attack** | 1,000 mg IV daily × 5 days; inadequate response → escalate to plasma exchange without delay. |
| **Infusion rate** | Over at least 30 minutes; cardiac arrhythmias and arrest have been reported with rapid administration of large doses. |
| **Oral taper** | Not routinely required after a relapse course; if used, individualize (e.g., prednisone taper over 1–2 weeks). |

### Standing orders — every infusion

- ☐ Blood pressure and (in at-risk patients) blood glucose each treatment day.
- ☐ Daily review: sleep disturbance, mood change, GI symptoms, infection signs.
- ☐ Counsel that metallic taste, facial flushing, and insomnia are common and self-limited.
- ☐ Document the response assessment plan (1–4 weeks post-course) before the patient leaves the last visit.

**Missed or delayed dose**

Complete missed daily doses as soon as possible within the treatment window; do not extend the total course beyond 5 days without specialist reassessment.

## Section 3 — Follow-Up Protocol

| ITEM | FREQUENCY / TIMING | ACTION / THRESHOLD |
|---|---|---|
| Blood glucose | Each treatment day in diabetic/at-risk patients | Marked hyperglycemia → treat per diabetes plan; consider holding remaining doses. |
| Blood pressure | Each infusion day | Hypertensive urgency → hold and manage. |
| Serum potassium | With repeated courses or risk factors | Correct hypokalemia. |
| Clinical response | 1–4 weeks after course completion | Inadequate response → escalate per condition (e.g., PLEX for NMOSD) and revisit the DMT plan. |

## Section 4 — Pause vs. Stop Criteria

**A. Pause or delay (resume when resolved)**

| CRITERION | REQUIRED ACTION |
|---|---|
| Intercurrent infection mid-course | Hold remaining doses pending evaluation. |
| Severe hyperglycemia or hypertensive urgency | Manage first; resume when controlled. |

**B. Discontinue permanently**

| CRITERION | REQUIRED ACTION |
|---|---|
| Anaphylactoid/severe hypersensitivity reaction | Stop; manage; document allergy. |
| Acute steroid psychosis or mania | Stop; psychiatric management. |

## Section 5 — Notes & Practical Points

- ☐ Frequent steroid courses are a signal, not a strategy: repeated relapse treatment should trigger a DMT escalation review.
- ☐ Document cumulative annual steroid exposure — osteoporosis and metabolic risk accrue.

**Prepared November 2026 by Madison Neurology LLC.**

This document is an educational compilation and does not reproduce the complete prescribing information. Verify every element against the current FDA label and applicable REMS requirements before clinical use.

- Current U.S. prescribing information via NIH DailyMed — https://dailymed.nlm.nih.gov/dailymed/
- FDA Drugs@FDA database — https://www.accessdata.fda.gov/scripts/cder/daf/
- FDA drug safety and availability updates — https://www.fda.gov/drugs/drug-safety-and-availability

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Questions about infusion referrals: call 608 403 0000. Neurology Care 7 days a Week. Because Your Brain Matters.