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Reply from the Author: Dr. Rivera and I do not disagree that the adverse reactions to intrathecal Depo-Medrol are dose-related and that Depo-Medrol is not as necrotizing to tissues within the subarachnoid space as are the soluble steroid preparations. We do disagree, however, about the safety and rationale of intrathecal steroid injections.

In my review,¹ I summarized the animal and human evidence that all currently marketed steroid preparations contain chemicals noxious to brain, spinal cord, or leptomeninges. In recognition of this toxicity, no steroid preparation is approved for intrathecal administration. Indeed, the presence in the preparations of solubility-altering glycols or bacteriostatic agents such as phenol or benzyl alcohol proves that they were neither designed nor intended for intrathecal administration. To administer these noxious agents intrathecally is to risk provoking known and expected toxic effects. That Dr. Rivera's patients seemed to escape these deleterious effects is fortunate, and may be due to the small doses and the low frequency of injections.

The review also noted the less than compelling rationale for intrathecal steroid administration. I do believe that a larger-dose bolus intravenous injection of soluble methylprednisolone sodium succinate (Solu-Medrol) is much safer than a smaller-dose intrathecal injection of Depo-Medrol or Solu-Medrol. Of course, whether any of these is of any therapeutic benefit has yet to be conclusively determined in any of the studies I summarized, including those of Dr. Rivera. The best designed and executed study of the effects of intrathecal Depo-Medrol on multiple sclerosis had to be abandoned

even before it could be completed due to the unacceptably high incidence of adverse effects.² The authors' concluding remark is worth repeating here: "[Intrathecal steroid therapy] probably adds to the risks borne by patients with multiple sclerosis."

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1. Bernat JL. Intraspinal steroid therapy. *Neurology (Ny)* 1981;31:168-71.
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Corrections

"Myasthenia gravis: Relation between jitter in single-fiber EMG and antibody to acetylcholine receptor" by Tetsuro Knoishi, Hiroshi Nishitani, Fumiyo Matsubara, and Mitsuhiro Ohta, April 1981, pp. 386-92. On p. 389, the figure 4 caption should be moved to the figure in the right column, and the figure 5 caption should be moved to the figure in the left column.

"Lateral and third ventricular CSF formation after metrizamide CT ventriculography" by V. Dhawan, M. D. F. Deck, and D. A. Rottenberg, May 1981, pp. 606-10. In the Table (Data summary) the rate of lateral ventricular CSF formation for patient II (I₂ in row 2) should read 0.101. In the Mathematical Appendix, Equations 2(a), 2(b), 2(c), 3(a), and 3(b), the subscripts 31, 32, 03, and 3L should be printed in small type.

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Corrections

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