Letter to the Editor

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Megadose Methylprednisolone (MDMP) for the Treatment of Steroid Refractory Patient with Diamond-Blackfan (D-B) Anemia

Diamond-Blackfan Anemisinin Megadoz Metilprednizolon ile Tedavisi

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To the Editor,

Dr. Malbora [1] and his colleagues reported metoclopramide in addition to corticosteroid in the treatment of a patient with steroid refractory Diamond-Blackfan (D-B) anemia in the recent issue of the Journal [1].

Although corticosteroid treatment had been used in the treatment of patients with D-B anemia, I reported first time that MDMP is effective (in appropriate doses) and safe in those patients including refractory and resistant cases [1-14], which was supported by Bernini et al'[15] from USA.

Therefore, I was underimpression that MDMP would be preferred treatment for those patients including steroid refractory and resistant ones.

I would like to reemphasize that MDMP is different than pulse methylprednisolone and conventional corticosteroid administration as was used for D-B anemia [5,6] long period as advised. In conventional corticosteroid treatment 1-2 mg/kg/day dose in gven 6-8 or 12 hours intervals. In pulse methyprednisolone treatment 1 g methlyprednisolone (MP) is giving i.v within 4 hours, at any time of the day.

In MDMP treatment, methylprednisolone MP initial dose 30-100 mg/kg day is given within 10 to 15 minutes IV or at once orally arouned 6 am, 3 days then 20-50 mg/kg, day for 4 days subsquently 10,5,2,1 mg/kg dose given for 1 week each according to response).

Although the authors also used 30 mg/kg day for 3 days followed by 20 mg/kg day for 4days, which were suggested by us for only acule ITP cases [15].

I would like to bring to the attention that clorpromide is potentially carcinogenic drug but methylprednisolone when administered as suggested by us, does not have any serious side effcs as supported by Bernini et al [16].

Importantly, I would like take to add that the very first patient treated by MDMP has been in remission about 30 years.

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Dear Editor,

We are grateful for correspondence by Prof. Özsoylu. In our patient, we administered pulse steroid with a dose of 30 mg/kg/day for three days, followed by 20 mg/kg/day which is tapered weekly (Figure 1 of our letter). Our patient used steroid treatment for 20 weeks before metoclopramide treatment. We administered all steroid doses at once in the morning between 6-8 a.m. We believe this protocol is in line with the references mentioned by Prof. Özsoylu. It has also been mentioned that clorpromide is a potentially carcinogenic drug. However, we administered metoclopramide to our patient instead of clopromide. Although in some studies metoclopramide is accused to have an indirect relation with breast cancer, this effect has not been confirmed yet (ref. 9).

Sincerely,

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