THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

Steroid Tapering Guidance

Many patients will receive moderate- to high-dose steroid therapy for their immune-related toxicity for several weeks. Length of tapering is usually dictated by the severity of the irAE. Regular monitoring during tapering is strongly advised as there is an increased risk of irAE recurrence.

Oral steroid tapering:

- Initiate corticosteroid taper over 3-6 weeks

Tapering guidance:

- Monitor patient during taper.
- Reduce prednisolone dose by 10mg every 3 days (as toxicity allows) until dose is 10mg/day.
- Once steroid dose is 10mg/day continue for 5 days then reduce to 5mg for 5 days then stop.

Please provide full course of steroid tapering

ALL PATIENTS SHOULD HAVE A 9AM CORTISOL CHECKED WITHIN THE 5-7 DAYS FOLLOWING COMPLETION OF THEIR STEROID TAPER

Intravenous steroid tapering:

- Corticosteroid taper over at least 3-6 weeks

Tapering guidance:

- Continue IV methylprednisolone 2mg/kg/day for a total of 5 days then switch to oral prednisolone 60mg/day
- If following a re-flare and reintroduction of IV steroids reduce to 1mg/kg/day of prednisolone PO for 3 days then commence taper.

Upon discharge:

- Monitor patient during taper.
- Reduce prednisolone dose by 10mg every 5 days (as toxicity allows) until dose is 10mg/day.
- Once steroid dose is 10mg/day, reduce by 5mg for 5 days then stop

Please provide full course of steroid tapering

Supportive measures:

Hyperglycaemia:
A baseline HbA1c should be requested at steroid initiation and random blood sugar monitoring (BM) alongside biochemical monitoring should be undertaken whilst on treatment. If new hyperglycemia is detected, then the UK Chemotherapy Board and The Joint British Societies for Inpatient care joint guideline on the management of glycaemic control in patients with cancer should be followed including advice from local endocrinology teams. Patients may require oral anti-diabetic medication or insulin in the short term.

Insomnia:
This is the most common steroid-related side effect. Sleep hygiene counselling is important. Patients may require short-term use of zopiclone (benzodiazepines should only be considered in rare circumstances for a max 3-5 days). Patients should be counseled about the importance of early morning steroid administration.

Osteoporosis:
Vitamin D and calcium levels should be taken at baseline and if low, replaced as appropriate. In patients on steroids for >3 months, or with pre-existing osteoporosis, a bone density scan and AdcalD3 and alendronate (or another bisphosphonate should be considered)

Infection:
In patients receiving the equivalent of prednisolone 25mg for ≥ 6 weeks or 2 or more immunosuppressant's, PCP prophylaxis with co-trimoxazole (800/160mg Mon/Wed/Fri) should be considered (incidence of PCP in this patient group is very low).

The oropharynx should be monitored for candidiasis and may require topical therapy such as Nystatin or oral antifungals. Azole antifungals commonly cause hepatitis and so should be used with caution in prophylactic setting.

If patients are on other immuno-modulatory agents e.g. Mycophenylate mofetil (MMF), consideration may be given to CMV prophylaxis with gancyclovir, especially if CMV IgG negative and lymphopenic. Acyclovir prophylaxis should be considered in patients who are immune-suppressed and have required treatment for oral viral infection.

General:
Ensure all patients are given a national Steroid Alert Card when commencing on corticosteroids.
Ensure steroid sick day rules are implemented as required.

IF PATIENT CANNOT TAKE STEROIDS FOR ANY REASON, THEY SHOULD SEEK URGENT ADVICE VIA THEIR LOCAL HOTLINE NUMBER OR EQUIVALENT.

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