Guidelines for Corticosteroid Use in Palliative Care

- Review all "less toxic" alternatives before considering starting Corticosteroids
- Document each stage of corticosteroid plan e.g. indication(s), expected outcome(s), predicted timescale of response, and date of corticosteroid review
- Clarify the individual risk : benefit ratios for each patient:
  (a) Ensure specified indication(s) reflect current best practice
  (b) Discuss spectrum/incidence of adverse effects with the patient to "consent"
  (c) Highlight any need for additional caution
- Dexamethasone is the corticosteroid of choice. Empirical doses are only a guide. Start at a relatively high dose to ensure any effect is not missed :

Dexamethasone starting dose*	Indications
2-4mg	♦ anorexia ♦ to improve wellbeing / mood ♦ weakness ♦ non-specific pains
4-8mg	♦ nerve compression pain ♦ liver capsule pain ♦ as an anti-emetic ♦ bowel obstruction ♦ to combat post radiation inflammation
12-16mg	♦ raised ICP ♦ SVCO ♦ Carcinomatosis lymphangitis ♦ malignant spinal cord compression

*Consider doubling the dose for patients on Phenytoin, Carbamazepine or Phenobarbitone.

- Prescribe Dexamethasone as a single morning dose, (or 2 morning doses if numerous tablets are required).
- Consider prophylactic prescribing of gastric protectants (Lansoprazole 30mg OD and / or Misoprostol 200mcg BD) if on a concurrent NSAID, and possibly if a previous history of PUD, or a cumulative corticosteroid dose of >140mg Dexamethasone (or equivalent)
- Consider prophylactic topical oral anti-fungals - Nystatin 2ml QDS, if any present or prior oral symptoms.
- Use a 5 – 7 day corticosteroid trial and discontinue abruptly unless a clear clinical benefit is seen. If a corticosteroid response is uncertain (usually maximal between 3 and 7 days), consider a trial of up to 3 weeks, where abrupt withdrawal is still possible.

- When beneficial, corticosteroids should only be continued at a set dose for a maximum of 2-4 weeks, with a planned review date to consider corticosteroid withdrawal.
- Taper corticosteroids to the lowest dose required clinically, aim for Dexamethasone 4mg or less. Even when benefits are noted "maintenance therapy" should be avoided. Patients should always be on a reducing scale of corticosteroids, though this may incorporate dose increases or fixed periods of a stable dose (2 – 4 weeks) while continuing the overall weaning process.
- Involve the patient and other healthcare professionals in the corticosteroid management plan. All patients requiring ongoing corticosteroids need to be aware of the necessary basic precautions:
  - Mechanisms, indications and formulations of corticosteroids
  - Side effects of corticosteroids, and the need for short courses
  - Advice against stopping corticosteroids abruptly and indications for additional doses
  - Symptoms to watch for and action to take while corticosteroids are being tapered down
  - The need to seek medical help if more unwell while taking corticosteroids, or come into contact with infectious diseases, particularly chickenpox if not previously infected which requires urgent medical attention
  - The need to carry a corticosteroid card (and possibly a Medic Alert bracelet) and to inform anyone treating them that they are on corticosteroids (and for one year after stopping them)
- Discontinue corticosteroids as soon as benefit is lost. However for corticosteroid doses greater than 6 - 8mg of Dexamethasone (or equivalent), or following periods longer than 3 weeks continuous use, corticosteroids should be discontinued gradually, under supervision, (time allowing). Reduce doses rapidly until nearing physiological doses i.e. Dexamethasone 1mg daily (or equivalent);

Dexamethasone, daily doses	**Empirical dose reductions**
above 2mg	reduce by 2 - 4mg every 5-7 days (and check for symptoms before the next dose drop), until reaching 2mg
2mg or less	reduce by 0.5 - 1mg every 5-7 days, or on alternate days for a more conservative approach

- For Dexamethasone doses above 4mg daily, consider checking random blood glucose during first 2 – 4 weeks of treatment or whenever possible symptoms.
- If corticosteroid induced myopathy occurs, reduce the dose and consider a switch to Prednisolone, and aim for <30 mg (or equivalent).
- As benefit is unlikely from withdrawal for patients in the terminal phase (<1-2 weeks prognosis), consider continuing corticosteroids.
- If the oral route is not available, ongoing corticosteroids should be given by subcutaneous infusion at equivalent doses, or for small volumes via a S/C stat line. Minimise the risks of precipitation by: adding last; and mixing slowly at body temperature (warmed in hand)
- For patients on corticosteroids or recently discontinued (1 week for a short course or 12 months for a course lasting months/years) consider additional doses for physiological stresses; pain; infection / fever; hypovolaemia; trauma e.g. fractured femur; and dying.