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 by telephone twice weekly during taper.
- Reduce prednisolone dose by 10mg every 3 days (as toxicity allows) until dose is 10mg/day.
- Once steroid dose is 10mg/day, reduce by 5mg every 5 days then stop.

Intravenous steroid tapering:

- Corticosteroid taper over at least 6 weeks

Tapering guidance:

- Continue IV methylprednisolone 2mg/kg/day for a total of 5 days then switch to oral prednisolone 1mg/kg/day x 3 days, then reduce to 60mg/day Prednisolone.
  Upon discharge:
- Monitor patient by telephone twice weekly during taper.
- Reduce prednisolone dose by 10mg every 7 days (as toxicity allows) until dose is 10mg/day.
- Once steroid dose is 10mg/day, reduce by 5mg every 7 days then stop

Supportive measures:

Hyperglycaemia:

A baseline HbA1c should be requested at steroid initiation and random afternoon blood sugar monitoring (BM) should be undertaken whilst on treatment. If new hyperglycemia is detected, Endocrinology advice should be sought (many patients will require short term insulin in this setting). Pre-existing diabetes may require escalation in oral hypoglycemic agents or insulin.

Insomnia:

This is the most common steroid-related side effect. Sleep hygiene counselling is important. Patients may require short-term use of zopiclone or benzodiazepines such as temazepam.

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, risedronate or another bisphosphonate should be considered.

Infection:

In patients receiving the equivalent of prednisolone 25mg for ≥ 6 weeks we suggest PCP prophylaxis with co-trimoxazole (80/400mg Mon/Wed/Fri).

The oropharynx should be monitored for candidiasis and may require topical therapy such as Nilstat or even oral fluconazole.

If patients are on other immuno-modulatory agents eg Mycophenylate mofetil, consideration may be given to CMV prophylaxis with valgancyclovir, especially if CMV IgG negative and lymphopenic.