

# FACTSHEET: STEROIDS IN PALLIATIVE CARE

Steroids can be a useful treatment in palliative care due to their anti-inflammatory action, however there are a number of risks and side effects limiting their use.

## Common indications for steroids in palliative care

- Cerebral oedema secondary to brain metastases
- Malignant spinal cord compression
- Pain secondary to nerve root compression
- Superior vena cava compression/obstruction
- Obstruction of a hollow viscus (e.g. bronchus)
- Liver capsule pain

## Indications where steroids are less helpful

In some centres, steroids have been traditionally used for indications including:

- Appetite stimulation
- “Energy boost”/fatigue management
- Vomiting/bowel obstruction

Any boost to appetite or energy levels is often transient and minimal, and given that steroids are associated with a significant side effect burden we would not recommend steroids for these indications. With bowel obstruction, steroids may contribute to the risk of GI irritation, bleeding or perforation so we would advise receiving specialist input when considering steroids in this context.

**Side effects, cautions and interactions** - Please see the current BNF

## Patients on immunotherapy

Patients prescribed immunotherapy agents (e.g. nivolumab) should **not** routinely be prescribed short courses of steroids for symptom management without discussion with the treating oncology team. Immunotherapy agents to treat cancer rely on an intact immune system. High dose steroids are the mainstay of treatment for immunotherapy-related adverse effects, but if such an effect is suspected treatment should have already been suspended

## Cessation and withdrawal

Abrupt withdrawal of systemic steroids can result in acute adrenal insufficiency. If a patient has had 1-3 weeks of treatment, a reducing dose is recommended. For > 3 weeks a reducing dose is crucial.

## Prescription

- Dose should be prescribed as a single AM dose where possible
- Prescribe a PPI (e.g. Lansoprazole) or H2 receptor blocker (e.g. Famotidine) unless contraindicated
- All patients should have consideration for side effects from steroids and be reduced as soon as possible to the lowest effective dose over the shortest duration that provides symptom relief
- Blood sugar monitoring should be considered in all patients taking long term steroids

## Suggested starting dose

- Cerebral oedema secondary to brain metastases
  - Mild to moderate symptoms 6-8mg OD
  - Severe symptoms 12-16mg OD (and consider escalation of care)
  - The majority of patients will need a long-term maintenance dose
- Malignant spinal cord compression
  - Dexamethasone 16mg OD until radiotherapy started, then reducing dose over 1-2 weeks
  - 25% will need long term maintenance dose
- Pain secondary to nerve root compression, obstruction of a hollow viscus, liver capsule pain
  - Dexamethasone 4-8mg OD dependent on severity. Stop after 5-7 days if no benefit
- SVC obstruction – only if stenting or radiotherapy not an option
  - Dexamethasone 8-16mg OD

## Parenteral steroids

If issues with medication absorption or ability to manage oral medication arise, steroids should be administered via once daily subcutaneous injection. Dexamethasone 2mg PO is approximately equivalent to 1.65mg SC (base), therefore:

- Dexamethasone 4mg PO = 3.3mg SC base
- Dexamethasone 6mg PO = 4.95mg SC base
- Dexamethasone 8mg PO = 6.6mg SC base

Dexamethasone is available in 3.3mg/ml or 6.6mg/2ml preparations. The maximum volume that can be given as a single SC Injection is 2ml, so doses exceeding 6.6mg SC will need to be split.

**FOR FURTHER ADVICE**

**Please contact The Kirkwood 24 hour advice line on 01484 557910**