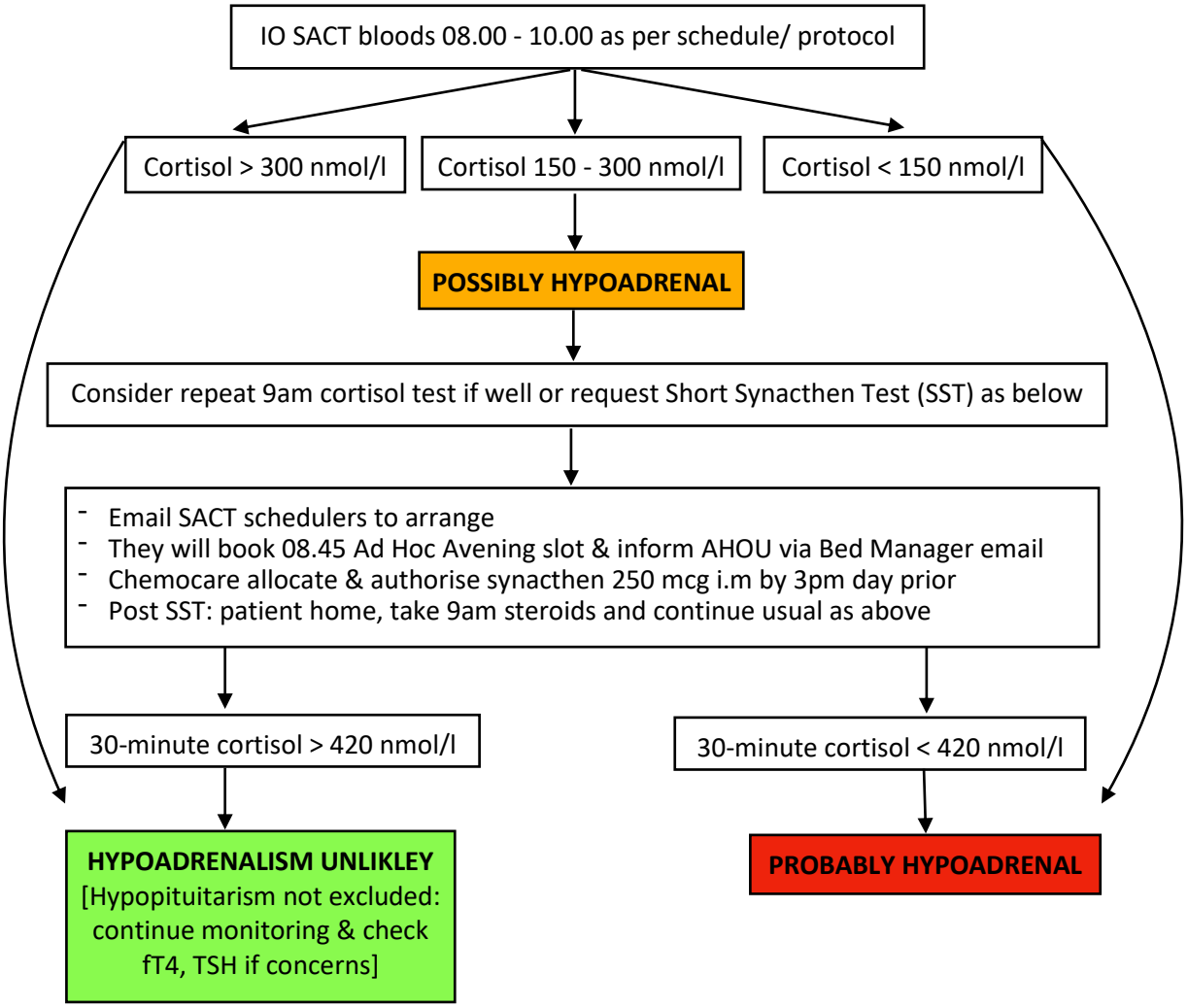
Gloucestershire Hospitals NHS Foundation Trust

GHT ONCOLOGY IO HYPOADRENALISM PATHWAY

NOTES

- Pathway as per NICE Guidance on Adrenal Insufficiency: https://www.nice.org.uk/guidance/ng243
- For clinically stable patients on immunotherapy (IO)
- Applicable to other settings where hypoadrenalism suspected (e.g. post cranial RT)
- If symptomatic/ unwell consider acute admission/ endocrinology referral
- Hypoadrenalism cannot be diagnosed on random cortisol level or if patient is on steroids
  - If on steroids: ignore results; if clinical concern: repeat testing as below:
    - If patient on Dexamethasone or Prednisolone: stop for ≥ 48 hours pre-test
    - If patient to remain on steroids post-test:
      - Switch to hydrocortisone for > 48 hours pre-test
      - Omit dose night before and morning of test (and the same for inhaled hydrocortisone)



ACTIONS

- Prescribers and pharmacy team responsible for monitoring routine protocol IO SACT blood tests
- Labs to call AHOU with hypocortisolaemia detected on routine bloods
- SST results: AHOU to check at 8.30pm & 9am post test & discuss with on-call Resident Doctor/ SPR
  - If normoadrenal: document on Chemocare
  - If hypoadrenal, Resident Doctor to call patient:
    - If patient well: AHOU review in-hours, start PO hydrocortsione 20mg am, 10mg midday, 10mg pm
    - If patient unwell: admit immediately, start iv hydrocortisone 50mg QDS + iv fluids +/- sepsis Rx
    - Send bloods for TSH and fT4
    - When patient home on steroids, provide steroid card & inform re sick day rules as per GHT policy

Approved by: GHNHSFT SACT Subgroup
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