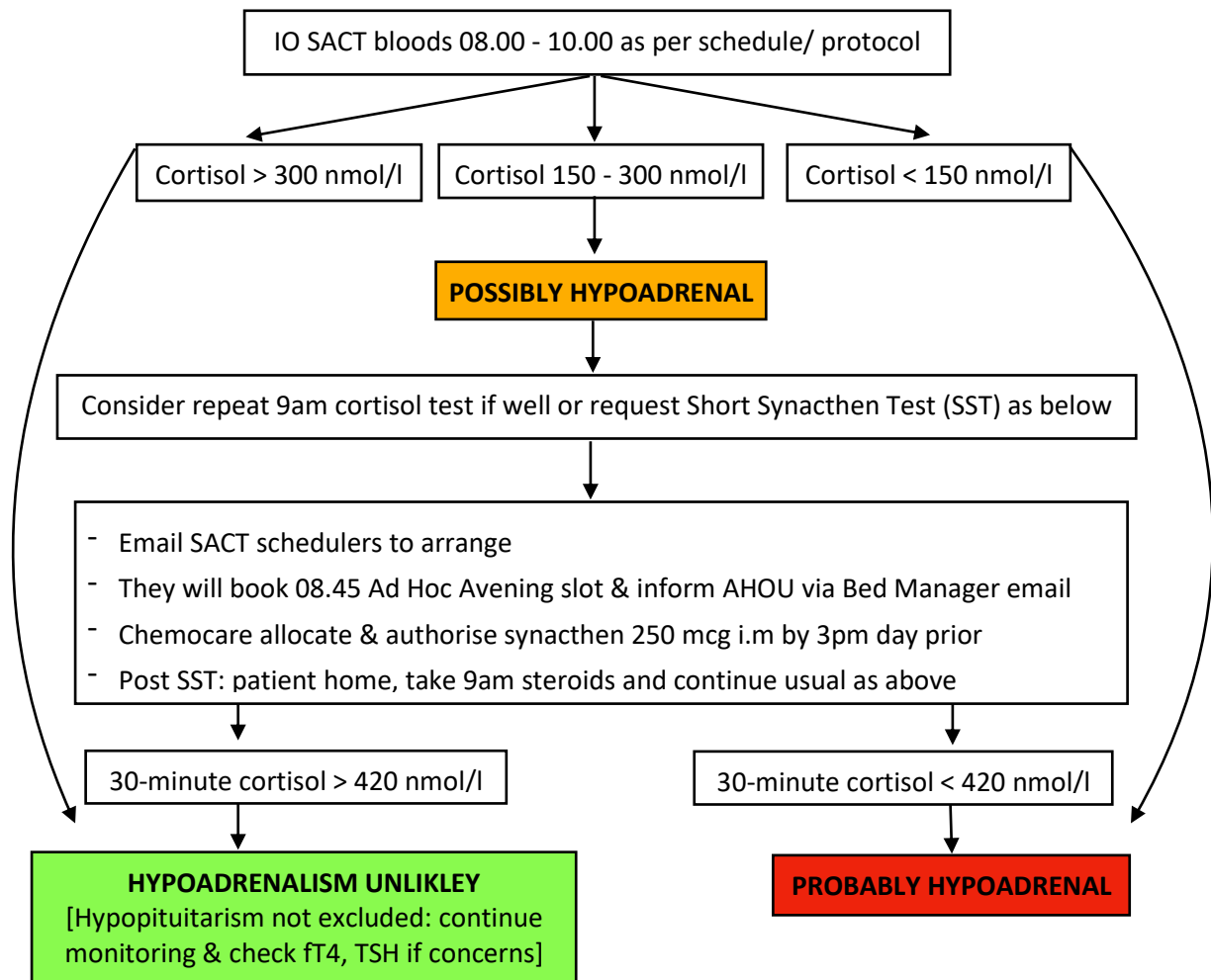


GHT ONCOLOGY IO HYPOADRENALISM PATHWAY

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 hydrocortisone 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
 - Refer patient to oncology practice development for emergency IM hydrocortisone injection training
 - Give prescription to main pharmacy "Hydrocortisone Sodium Succinate 100mg IM injection x 2 [emergency kit]" (practice development will collect on day of training)