Steroid withdrawal

May cause a flare-up of the underlying condition for which steroids were prescribed.

When the risk of HPA suppression is low (as is the case with short courses of steroids for less than ≈ 5–7 days generally prescribed for most neurosurgical indications) abrupt discontinuation usually carries a low risk of AI. For up to ≈ 2 weeks of use, steroids are usually safely withdrawn by tapering over 1–2 weeks. For a longer treatment, or when withdrawal problems develop, use the following conservative taper:

1. make small decrements (equivalent to 2.5–5 mg prednisone) every 3–7 d. Patient may experience mild withdrawal symptoms of:

a) fatigue

b) anorexia

c) nausea

d) orthostatic dizziness

2. “backtrack” (i.e., increase the dose and resume a more gradual taper) if any of the following occur:

a) exacerbation of the underlying condition for which steroids were used

b) evidence of steroid withdrawal symptoms

c) intercurrent infection or need for surgery; see Stress doses

3. once “physiologic” doses of glucocorticoid have been reached (about 20 mg hydrocortisone/day or equivalent:

a) the patient is switched to 20mg hydrocortisone PO q AM(do not use long-acting preparations)

b) after≈2–4weeks, a morning cortisol level is checked (prior to the AM hydrocortisone dose), and the hydrocortisone is tapered by 2.5 mg weekly until 10 mg/d is reached (lower limits of physiologic)

c) then, every 2–4 weeks, the AM cortisol level is drawn (prior to AM dose) until the 8 AM cortisol is > 10 mcg/100 ml, indicating return of baseline adrenal function

d) when this return of baseline adrenal function occurs:

● daily steroids are stopped, but stress doses must still be given when needed

● monthly cosyntropin stimulation tests are performed until normal. The need for stress doses of steroids ceases when a positive test is obtained. The risk for adrenal insufficiency persist ≈ 2 years after cessation of chronic steroids (especially the first year)