

GRADE

1 • Strong

2 • Suggest

Good Clinical Practice

1 General Principles

GPS

Most patients on or tapering glucocorticoids for **non-endocrine conditions do not need endocrinology referral**. Educate all patients on the endocrine aspects of glucocorticoid therapy and provide access to current, appropriate information.

2 Tapering & Who's At Risk

SCENARIO	APPROACH
Short-term therapy (<3–4wk)	No taper needed regardless of dose – stop without testing (low HPA-suppression concern)
Long-term therapy, disease controlled	Taper only once underlying disease is controlled and GC no longer needed; taper to physiologic dose equivalent (~4–6 mg prednisone)
Supraphysiologic dose or ongoing disease need	Against routine adrenal insufficiency testing
Long-acting GC (dexamethasone, betamethasone)	Switch to short-acting (hydrocortisone, prednisone) once no longer needed
At-risk for unrecognized AI	Current/recent non-oral GC with AI symptoms; multiple simultaneous GC formulations; high-dose or >1y inhaled/topical GC; intra-articular injection within 2 months; concomitant strong CYP3A4 inhibitors
Exogenous Cushing signs/symptoms	Assume glucocorticoid-induced adrenal insufficiency is present

3 Withdrawal Syndrome & Diagnosis

GPS

Withdrawal syndrome can occur during taper – if severe, temporarily increase to the last-tolerated dose and extend the taper duration.

2

Confirm HPA recovery with **AM serum cortisol** as first test: **>300 nmol/L (10 µg/dL)** → stop GC safely; **150–300 nmol/L (5–10)** → continue physiologic dose, recheck in weeks–months; **<150 nmol/L (5)** → continue physiologic dose, recheck in a few months.

2

Against routine dynamic testing for adrenal insufficiency in patients tapering/stopping GC. If not recovered after **1 year** on a physiologic dose, or with a **history of adrenal crisis**, refer to endocrinology.

1

Against fludrocortisone in glucocorticoid-induced adrenal insufficiency.

4 Adrenal Crisis: Stress Dosing & Diagnosis

GPS

Patients with current/recent GC use **not biochemically tested** for AI should receive **stress-dose coverage** when stressed: **oral GC** for minor stress without hemodynamic instability/vomiting/diarrhea; **parenteral GC** for moderate–major stress, procedures under anesthesia, prolonged NPO, or hemodynamic instability/vomiting/diarrhea.

GPS

Consider **adrenal crisis** in any patient with current/recent GC use plus hemodynamic instability, vomiting, or diarrhea – regardless of GC type, route, or dose – and treat empirically with **parenteral glucocorticoids**.