NHS Sheffield CCG Guide for the Use of the New Steroid Emergency Card – Adult (16+)

This guide supports the national directive to issue an NHS Steroid Emergency Card to all patients with adrenal insufficiency or steroid dependence as they are at risk of an adrenal crisis during intercurrent illness or an invasive procedure/surgery if not managed appropriately.

Contents

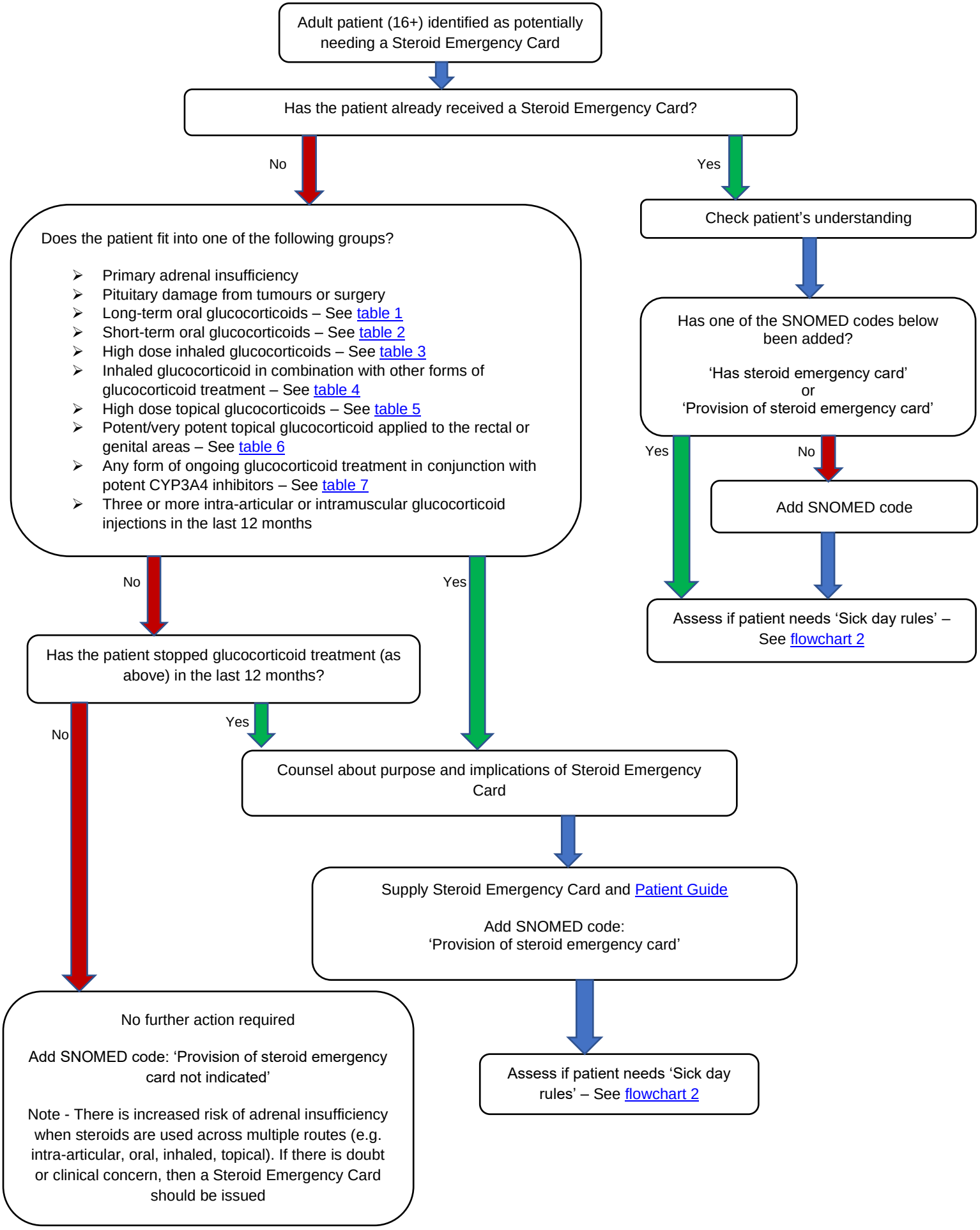
Version History

Version number	Date	Details of change
V1	September 2021	New document approved by APG

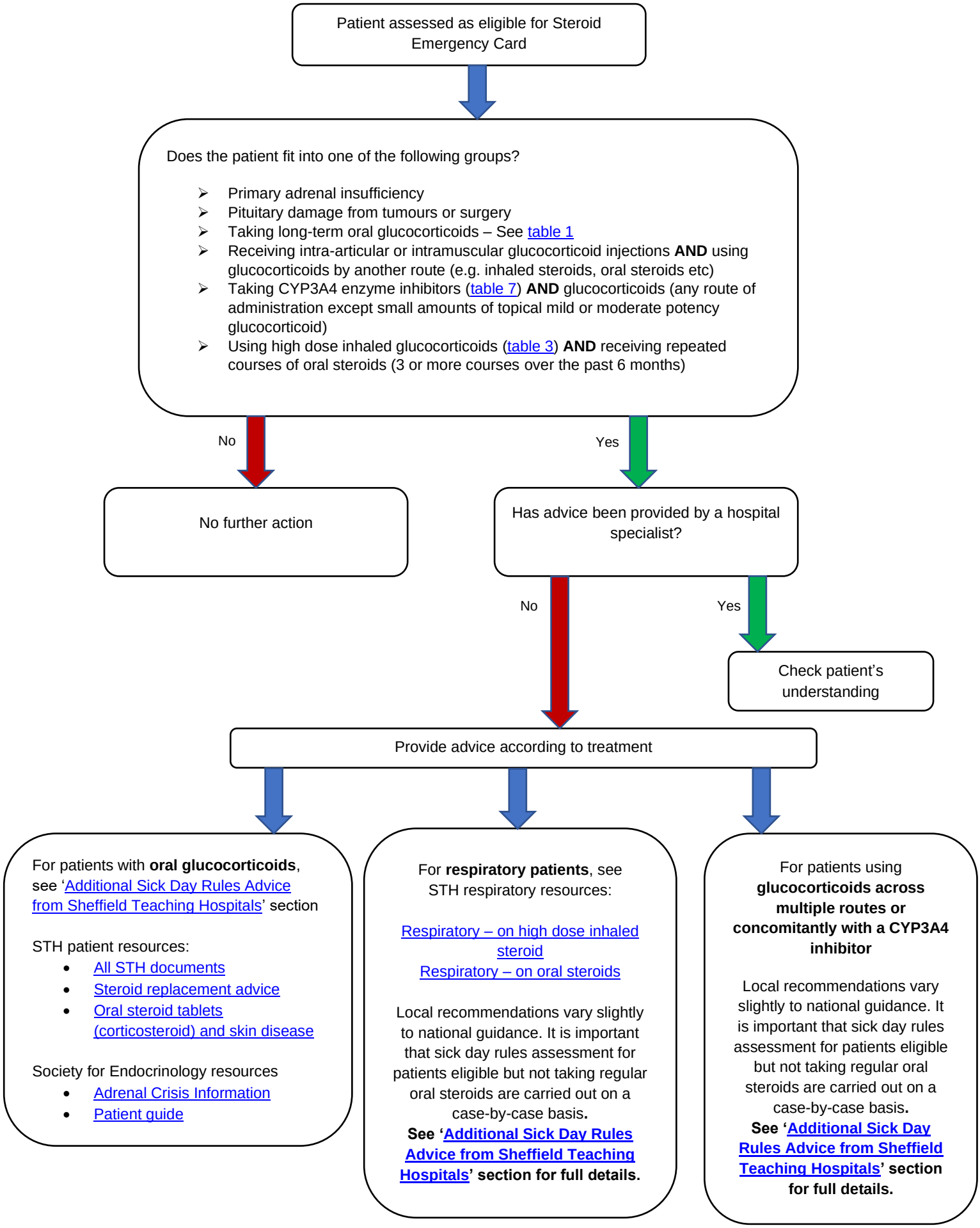
Key Points

- Adrenal insufficiency (AI) is a disorder that occurs when the adrenal glands do not make enough of certain hormones.
- Acute adrenal crisis is a life-threatening condition that occurs when there is not enough cortisol.
- This guide is to support the implementation of the National Patient Safety Alert published in August 2020 to reduce risk of adrenal crisis.
- Please use this guide as a support tool to help identify patients who may require a steroid emergency card, including information on available clinical system support (Appendix 2).
- This card and its associated guidance is intended for use by adults (aged 16+).
- **Some** patients eligible for a Steroid Emergency Card will also require additional 'sick days rules' advice which is included in this guide.
- Patients should be appropriately counselled to make sure they understand the implications of the card that they are receiving AND the importance of continuing with steroid medication.
    - This is particularly important for those using inhaled corticosteroids (ICS). If the Steroid Emergency Card is supplied without proper counselling, there is a risk of the patient becoming anxious due to the information on the card. This may result in reduced compliance / stopping their ICS and the outcome of poor disease control may be worse than their risk of adrenal insufficiency.
    - Please ensure a discussion is held with all patients on ICS prior to issuing a steroid emergency card so that any concerns can be addressed.
    - This may be an ideal opportunity to discuss inhaled corticosteroid withdrawal for appropriate COPD patients (see Sheffield ICS withdrawal protocol) or to discuss stepping down treatment in asthma where appropriate (see Sheffield asthma guideline).
- There is increased risk of adrenal insufficiency when steroids are used across multiple routes (e.g. intra-articular, oral, inhaled, topical). If there is doubt or clinical concern, then a Steroid Emergency Card should be issued.
- STH provides different advice to their respiratory patients based on whether or not they are on oral corticosteroids. Patient information leaflets for these two groups can be found here – please use these to support advice to respiratory patients.
- The use of the blue steroid **treatment** card is currently unaffected by the introduction of the NHS Steroid **Emergency** Card. Patients should keep these, if advised by their healthcare team whilst implementation of the new Steroid **Emergency** Card takes place and until they are supplied with the new Steroid **Emergency** Card.

Flowchart 1 - Assessing the need for a Steroid Emergency Card



Flowchart 2 – Assessing the need for 'sick day rules'



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Why have we produced this guidance?

In August 2020 a National Patient Safety Alert was published which highlighted the risk of adrenal crisis in certain groups of patients and the importance of using a steroid emergency card for the early recognition and treatment of adrenal crisis. We have worked collaboratively with STH colleagues to establish an approach to action this alert in a safe way. We are aware that individual practices may have started to action the alert however we hope this guidance will help support practices with this work and identify those patients who come under the alert.

Note: This card and its associated guidance is intended for use by adults (aged 16+).

What is adrenal insufficiency (AI)?

Adrenal insufficiency (AI) is a disorder that occurs when the adrenal glands do not make enough of certain hormones. These include cortisol which is sometimes called the stress hormone and is essential for life.

Examples of the most common causes of adrenal insufficiency are given below:

- **Primary AI** includes Addison's disease, congenital adrenal hyperplasia, adrenal haemorrhage or bilateral adrenalectomy. The adrenal glands are damaged and do not produce enough cortisol or aldosterone.
- **Secondary AI** occurs due to the absence of normal stimulation of the adrenal cortex from a lack of ACTH (adrenocorticotropic hormone) which is the hormone responsible for regulating levels of cortisol. This results in a partial or total deficiency of cortisol but often a normal or near normal production of aldosterone. Causes include pituitary tumours, pituitary damage from surgery or irradiation. However, the main cause of secondary AI is the use of glucocorticoid medication to treat a wide range of conditions and may include the use of oral, intra-articular, intravenous, topical and inhaled corticosteroids. Corticosteroid medications can supress the adrenal cortex and therefore the endogenous production of steroid hormones such as cortisol. A sudden cessation of corticosteroid medication can lead to secondary AI.

Adrenal insufficiency may not be apparent until a patient is put under stress such as through infection, trauma or surgery when the body requires the stress hormone cortisol or if external corticosteroids are stopped. This can lead to acute adrenal crisis.

What is adrenal crisis?

Acute adrenal crisis is a life-threatening condition that occurs when there is not enough cortisol. Symptoms can include:

- Headache
- Weakness and fatigue, slow sluggish movement
- Nausea and vomiting
- Low blood pressure and rapid heart rate, rapid respiratory rate
- High fever and chills
- Confusion or coma
- Darkening of the skin, skin rash or lesions may be present
- Joint pain, abdominal pain, flank pain
- Unusual and excessive sweating on face and/or palms
- Loss of appetite and unintentional weight loss

Who should be issued with a steroid emergency card?

These groups will require treatment cover with hydrocortisone if admitted to hospital unwell or if undergoing a surgical or invasive procedure. They should carry a steroid emergency card to warn appropriate emergency and healthcare staff of this. If the patient develops symptoms of adrenal insufficiency such as vomiting, diarrhoea, dizziness, fatigue or a flu-like illness, patient should seek medical advice.

- Patients with primary AI including Addison's disease and congenital adrenal hyperplasia.
- Patients with pituitary damage from tumours or surgery.
- Patients who have received a long-term course (>4 weeks) of oral glucocorticoids at a dose equivalent or higher than prednisolone 5mg (see Appendix 1, Table 1)
- Short-term high-dose oral glucocorticoids (≥ 1 week) where the patient has been on a long-term course within the last 12 months, **or** received 3 or more short courses within the last 12 months, and for 12 months after stopping (see Appendix 1, Table 2)
- 3 or more intra-articular/intramuscular glucocorticoid injections within the last 12 months, and for 12 months after stopping
- Repeated courses of dexamethasone as an antiemetic in oncology regimens, and for 12 months after stopping (the Steroid Emergency Card should be given on first cycle of dexamethasone) when future cycles are anticipated (Secondary care responsibility)
- Prolonged courses of dexamethasone (>10 days) for the treatment of severe Covid-19 (Secondary care responsibility)
- High dose Inhaled steroids >1000mcg/day beclometasone or >500mcg/day fluticasone (or equivalent dose of another glucocorticoid), and for 12 months after stopping (see Appendix 1, Table 3)
- Patients taking medium dose inhaled corticosteroids at doses described in Appendix 1, Table 4 **AND** any other form of glucocorticoid treatment (including potent/very potent topical glucocorticoids, intra-articular injection, regular nasal glucocorticoids).
- Topical high-dose (≥200g/ week) potent or very potent glucocorticoids used continuously across a large area of skin for 4 weeks or more, or factors increasing absorption, assessed on a case by case basis, and for 12 months after stopping. (see Appendix 1 Table 5)
- Potent or very potent topical glucocorticoids applied to the rectal (see Appendix 1 table 6) or genital areas and used at high dose (more than 30g per month) for more than 4 weeks, and for 12 months after stopping
- Patients prescribed any form of ongoing glucocorticoid treatment (except small amounts of a mild or moderate topical glucocorticoid which should be assessed on a case-by-case basis) in conjunction with medicines known to be potent CYP3A4 inhibitors (see Appendix 1 Table 7)

Further information to support this can be found at in Society for Endocrinology/SPS guidance

Who should be given a steroid emergency card and additional 'sick day rules' advice?

The following groups of patients are at increased risk of AI and require a Steroid Emergency Card AND advice regarding sick day rules if unwell outside of hospital:

1. Patients with primary AI including Addison's disease and congenital adrenal hyperplasia.
2. Patients with pituitary damage from tumours or surgery or other cause.
3. Patients taking oral prednisolone 5mg or above (or equivalent dose of other oral glucocorticoids) for more than 4 weeks, and for 12 months after stopping oral steroids (see Appendix 1, Table 1)
4. Patients receiving intra-articular or intramuscular glucocorticoid injections who also use glucocorticoids by another route (e.g. inhaled steroids, oral steroids etc)*
5. Concomitant use of CYP3A4 enzyme inhibitors (see Appendix 1, Table 7) and glucocorticoids (any route of administration except small amounts of topical mild or moderate potency glucocorticoid which should be assessed on a case by case basis)*
6. Patients with respiratory disease such as COPD and asthma on high dose inhaled steroids (see Appendix 1, Table 3) receiving repeated courses of oral steroids (3 or more courses over the past 6 months)*

These groups are at greater risk of significant HPA axis suppression. They may require cover with hydrocortisone if admitted to hospital unwell or when undergoing a surgical or invasive procedure. **See STH advice on the next page for sick day rules advice and when to consider supplying a patient with an additional steroid prescription to cover periods of illness etc**. Further information to support this can also be found in Society for Endocrinology/SPS guidance**.**

* Sick day rules for patients not taking regular oral steroids needs careful assessment. See STH advice on the following page.

STH have developed tailored advice for respiratory patients – see advice on the following page and where appropriate supply respiratory patient resources from STH website:

- Respiratory – on high dose steroid
- Respiratory – on oral steroids

Additional Sick Day Rules Advice from Sheffield Teaching Hospitals

Sick day rules assessment for patients not taking regular oral steroids (see 'Who should be given a steroid emergency card and additional 'sick day rules' advice' above - Groups 4 to 6)

Sick day rules assessment for these patients is complex and should be carried out on a case-by-case basis with careful consideration of all previous steroid exposure and potential features of adrenal insufficiency. Adrenal crisis in these patients is rare, but there is potential for confusion and harm if patients mistakenly use reserve 'sick day' steroids to treat exacerbations of underlying disease, e.g. asthma.

Consider diagnostic testing initially rather than issuing reserve 'sick day' steroids.

- Symptoms of adrenal insufficiency (e.g. weight loss, fatigue, dizziness, fainting, unexplained body pains) should prompt early assessment for this and other clinical conditions that can present similarly (malignancy, anaemia etc).
- Carry out an early morning (8.30am – 9am) cortisol test if adrenal insufficiency is suspected. If <300 nmol/l, refer to endocrinology services for synacthen tests. Consider issuing reserve 'sick day' steroids temporarily until they are seen.
- Reserve 'sick day' steroids for the specific purpose of preventing adrenal crisis should only be given to patients who have been confirmed to have adrenal suppression or possibly to those waiting adrenal assessment where it is judged that there is a significant risk. Some patients may also continue to receive reserve oral steroids separately for acute management of underlying diseases, such as asthma, at different doses and as part of personal action plans.
- A low threshold for suspicion of adrenal insufficiency should be maintained in these patients indefinitely with consideration of maintenance steroid dose reduction when underlying condition improves.
- Where adrenal insufficiency is suspected, during an acute illness there should be a low threshold for diagnosis of adrenal crisis and urgent referral to emergency medical services.

Advice for patients eligible for 'sick day rules' in addition to the Steroid Emergency Card

1. If experiencing heavy colds, temperature 37.5^{o}C or above or infections requiring antibiotics.
   - **For patients taking regular oral steroids (see 'Who should be given a steroid emergency card and additional 'sick day rules' advice' above - Groups 1 to 3)**: the patient will need 3-7 days of increased steroids as follows:
     - if on **hydrocortisone**, increase the oral dose (20mg immediate; then 10mg 6 hourly);
     - if on **dexamethasone** less than or equal to 1mg/day increase to 2mg/day;
     - if on **prednisolone** less than or equal to 5mg/day increase to 10mg/day (5mg BD) and if between 6 to 15mg/day increase to 15mg/day (7.5mg BD).

     Instead of doubling the dose of dexamethasone or prednisolone you can add on and prescribe 20mg hydrocortisone TDS.
   - **If eligible but not taking regular oral steroids (see advice about diagnostic testing above):** advise hydrocortisone 20mg stat and then 10mg 6 hourly or prednisolone 5mg bd to cover the sickness episode.

   Note: Patients should return to usual steroid dose when infection treated. If infection >7days discuss with doctor.

2. If vomiting, diarrhoea or very high fever and the patient is unable to swallow/absorb oral steroids,
   - Give **100mg IM hydrocortisone (Sodium Succinate powder** to reconstitute with 2ml water for injection **OR Sodium Phosphate solution for injection)**.
   - Refer the patient to emergency services.

     The specialist will assess, and where appropriate, prescribe and counsel patients requiring hydrocortisone IM injection (100mg). They will issue the patient with a hydrocortisone 100mg IM injection kit (which comes with a blue needle, 2ml syringe and a sharps bin). If a patient has the need to use their injection or it expires then there may be a requirement for the GP to prescribe a replacement hydrocortisone injection. The patient however should be asked to contact their hospital specialist secretary or nurse to provide replacement syringe/needles.

3. If any flare-up of underlying conditions:
   - Use additional steroids on top of the usual daily dose in accordance with routine practice and/or any advice from specialist teams. For patients on hydrocortisone, where additional acute steroids are given, use standard doses and add these to the hydrocortisone regimen, so that when the additional steroids finish, the patient remains on their maintenance hydrocortisone.

Advice and tools for practices

Prescribers need to ensure all eligible patients are assessed, reviewed, and issued with a steroid emergency card where appropriate. This should be done as a face to face/telephone consultation to ensure appropriate counselling and to reduce the risk of the patient becoming anxious due to the information on the card. This may result in reduced compliance/stopping their medication and the outcome of poor disease control may be worse than their risk of adrenal insufficiency.
It may be an ideal opportunity to discuss inhaled corticosteroid withdrawal for appropriate COPD patients see Sheffield ICS withdrawal protocol or to discuss stepping down treatment in asthma where appropriate see Sheffield asthma guideline.

Searches
A series of clinical system searches, based on the PrescQIPP conversion tables, have been published on SystmOne and EMIS Web. These will assist practices to identify the patients taking exogenous steroids who may potentially require a Steroid Emergency Card. It is important to be aware that these searches may not be exhaustive or may bring up patients who may not require a card therefore clinical judgement is still required.
See Appendix 2 for details on where to find the searches.

Protocol / Pop-ups
These are being developed to trigger for clinicians when prescribing a steroid containing medicine to prompt them to consider if the patient should have a Steroid Emergency Card and will allow for a card to be printed if necessary. It will also, where appropriate, automatically enter the SNOMED code.

Templates
The local templates for asthma and COPD are being amended to include a section specific to Steroid Emergency Card.

SNOMED Codes
In July 2021, a series of new SNOMED codes were released relating to the Steroid Emergency Card. These are as follows:

- **1326871000000108: Provision of steroid emergency card** (procedure) - a code for clinicians to record that they are issuing a steroid emergency card
- **1326891000000107: Has steroid emergency card** (finding) - a code to record that a patient already has a steroid emergency card
- **1326881000000105: Provision of steroid emergency card not indicated** (situation) - a code to represent that the provision of this card is not indicated at the time.
- **1362411000000108: Referral for provision of steroid emergency card** (procedure) – a code used to record when a clinician/prescriber does not have a supply of steroid emergency cards but has assessed the patient in line with the new national guidance and made the clinical decision that that the card is required. The patient would need to be referred to the agreed provider of the steroid emergency card.

Patients who were assessed prior to the above codes becoming available on the clinical systems may have been coded with one of the codes below:

112911000000105 – STC1 steroid treatment card
711121000000102 – Steroid treatment card issued

For patients assigned one of these codes, please consider updating to one of the specific Steroid Emergency Card codes.

Consider free texting when additional information on sick day rules is given.

Steroid Emergency Card Ordering information

The Emergency Steroid Card can be ordered from the usual suppliers:

a) NHS Forms at NHS Business Services Authority (NHS BSA) http://www.nhsforms.co.uk/
b) Primary Care Support England (PCSE online) https://secure.pcse.england.nhs.uk/_forms/pcsssignin.aspx

Patient resources

STH

STH have produced a number of patient information leaflets around this, see link where you will find the following leaflets:

- Steroid emergency card (Adult)
- High dose inhaled steroids for people with lung disease
- Steroid tablets for people with lung disease
- Oral steroid tablets (corticosteroid) and skin disease

(Note – more PILs are in development by colleagues at STH to support steroid use in other conditions, they will be added to their PIL webpage once approved)

PrescQIPP

Patient guide - NHS Steroid Emergency Card.docx

Society for Endocrinology

Provides various patient resources: https://www.endocrinology.org/adrenal-crisis

References

National patient safety alert https://www.england.nhs.uk/wp-content/uploads/2020/08/NPSA-Emergency-Steroid-Card-FINAL-2.3.pdf

Society for Endocrinology/Specialist Pharmacy Service Exogenous Steroids, adrenal insufficiency and adrenal crisis –who is at risk and how should they be managed https://www.endocrinology.org/media/4030/spssfe_supporting_sec_-final_hls-19022021-2-1.pdf

Society for Endocrinology - https://www.endocrinology.org/adrenal-crisis

PrescQIPP (https://www.prescqipp.info/news/prescqipp-hot-topics-implementing-the-nhs-steroid-emergency-card-national-patient-safety-alert-natpsa/)

Emily Parsons, Medicines Governance Pharmacist, NHS Sheffield CCG
Deborah Leese, Lead Pharmacist for Respiratory, NHS Sheffield CCG

STH advice provided by Dr Miguel Debono, Consultant Endocrinologist and Professor Ian Sabroe, Consultant in Respiratory Medicine

Approved by APG, September 2021
Review Date – September 2026

Appendix 1 – Tables to support patient identification

Please note these conversions are for adults only as the alert and current guidance applies to adults only (16 years and above).

These tables have been developed by STH and adopted from recommendations provided by PrescQIPP

Table 1 – Long-term oral glucocorticoids - Patients who have received a long-term course (>4 weeks) of glucocorticoids at a dose equivalent to or higher than prednisolone 5mg, and for 12 months after stopping

Oral steroids	5mg Prednisolone equivalent dose. Patients receiving this dose daily for 4 weeks or more should be issued a steroid emergency card
Betamethasone 500 microgram soluble tablets	≥750mcg
Beclometasone dipropionate 5mg gastro-resistant modified-release tablets Brand: Clipper®	≥625mcg
Budesonide 3mg capsules,9mg tablets/granules Brands: Entocort® Budenofalk® Cortiment®	≥1.5mg
Deflazacort 6mg tablets Brand: Calcort ®	≥6mg
Dexamethasone 500mcg, 0.5mg, 2mg, 4mg, 40mg tablets Dexamethasone 2mg, 4mg, 8mg soluble tablets Dexamethasone Oral solution 2mg/5ml, 10mg/5ml, 20mg/5ml Brands: Neofordex®, Glensoludex®	≥500mcg
Hydrocortisone 10mg, 20mg tablets Hydrocortisone 10mg soluble tablets Hydrocortisone 0.5 mg, 1mg, 2mg, 5mg granules in capsules for opening Brands Alkindi®	≥15mg
Methylprednisolone 2mg, 4mg ,16mg, 100mg tablets Brand Medrone®	≥4mg
Prednisolone 5mg tablets	≥5mg

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Table 2 – Short-term oral glucocorticoids - 3 or more short courses of high-dose oral glucocorticoids within the last 12 months, and for 12 months after stopping **or** one-week course or longer and has been on long-term course within the last year

Short Term Oral Glucocorticoids ≥1 week	Dose for which a steroid card should be issued if criteria above met
Betamethasone 500 microgram soluble tablets	≥6mg/day
Beclometasone dipropionate 5mg gastro-resistant modified-release tablets Brand: Clipper®	5mg/day
Budesonide 3mg capsules,9mg tablets/granules Brands: Entocort® Budenofalk® Cortiment®	12mg/day
Deflazacort 6mg tablets Brand: Calcort ®	≥48mg/day
Dexamethasone 500mcg, 0.5mg, 2mg, 4mg, 40mg tablets Dexamethasone 2mg, 4mg, 8mg soluble tablets Dexamethasone Oral solution 2mg/5ml, 10mg/5ml, 20mg/5ml Brands: Neofordex®, Glensoludex®	≥4mg/day
Hydrocortisone 10mg, 20mg tablets Hydrocortisone 10mg soluble tablets Hydrocortisone 0.5 mg, 1mg, 2mg, 5mg granules in capsules for opening Brands Alkindi®	≥120mg/day
Methylprednisolone 2mg, 4mg ,16mg, 100mg tablets Brand Medrone®	≥32mg/day
Prednisolone 5mg tablets	≥40mg/day

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Table 3 – High dose inhaled glucocorticoids – Patients receiving a total daily dose of >1000mcg beclometasone or >500mcg fluticasone (or equivalent) for 4 weeks or more, and for 12 months after stopping

Inhaled corticosteroids	5mg Prednisolone equivalent dose per day for 4 weeks or more for which steroid emergency card must be issued
Beclometasone dipropionate (BDP) is found in two formulations, standard and extrafine, in a variety of stand alone and combination inhalers	
MDI or dry powder forms in a variety of generic and proprietary inhalers including: Clenil® Modulite®, Soprobec®, Asmabec®	>1000mcg
Extrafine BDP as found in Qvar®, Fostair® Kelhale®, Trimbow®	>500mcg
Budesonide has a single equivalent potency whether in dry powder or MDI forms, and is found in a range of single drug and combination forms and devices	
Dry Powder and MDI forms in a range of inhalers, alone or in combination with other drugs, for example: Easyhaler®, Budolin® Novolizer®, Fobumix®, Pulmicort®, Symbicort®, DuoResp®	>1000mcg
Ciclesonide	
Aerosol Inhaler: Alvesco®	>480 mcg
Fluticasone propionate is distinct from fluticasone furoate. It is found in a range of single drug and combination forms and devices in dry powder and MDI forms	
Flixotide®, Flutiform®, Seretide®, Airflusal, and generic forms	>500mcg
Fluticasone furoate	
Dry powder inhaler: Relvar Ellipta®, Trelegy Ellipta®	> 100 mcg (ie 184mcg formulations)
Mometasone furoate occurs in proprietary inhalers that have different deposition/formulations and thus different potencies	
Dry Powder Inhaler: Asmanex®	> 800 mcg dose
Dry powder as Atectura	> 200 mcg dose
Dry powder as Enerzair	> 100 mcg dose

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Table 4 - Inhaled glucocorticoid doses requiring Steroid Emergency Card when used in combination with other forms of glucocorticoid treatment (incl potent/very potent topical glucocorticoids, intra-articular injection, regular nasal glucocorticoids).

Nasal Steroids (any dose) or Potent/Very Potent Topical Steroids and Inhaled corticosteroids	**5mg Prednisolone equivalent dose per day for 4 weeks or more for which steroid emergency card must be issued**
Beclometasone dipropionate (BDP) is found in two formulations, standard and extrafine, in a variety of stand alone and combination inhalers	
MDI or dry powder forms in a variety of generic and proprietary inhalers including: Clenil® Modulite®, Soprobec®, Asmabec®	>800 - 1000mcg
Extrafine BDP as found in Qvar®, Fostair® Kelhale®, Trimbow®	>400 - 500mcg
Budesonide has a single equivalent potency whether in dry powder or MDI forms, and is found in a range of single drug and combination forms and devices	
Dry Powder and MDI forms in a range of inhalers, alone or in combination with other drugs, for example: Easyhaler®, Budolin® Novolizer®, Fobumix®, Pulmicort®, Symbicort®, DuoResp®	>800 - 1000mcg
Ciclesonide	
Aerosol Inhaler: Alvesco®	> 320 - 480 mcg
Fluticasone propionate is distinct from fluticasone furoate. It is found in a range of single drug and combination forms and devices in dry powder and MDI forms	
Flixotide®, Flutiform®, Seretide®, Airflusal, and generic forms	>400 - 500mcg
Fluticasone furoate	
Dry powder inhaler: Relvar Ellipta®, Trelegy Ellipta®	> 100 mcg
Mometasone furoate occurs in proprietary inhalers that have different deposition/formulations and thus different potencies	
Dry Powder Inhaler: Asmanex®	> 400 – 800 mcg dose
Dry powder as Atectura	> 200 mcg dose
Dry powder as Enerzair	> 100 mcg dose

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Table 5 - Topical high-dose (>/= 200g/ week) potent or very potent glucocorticoids used across a large area of skin for 4 weeks or more, or factors increasing absorption, assessed on a case by case basis, and for 12 months after stopping.

Topical steroid treatments (≥200g/week for 4 weeks) (significant absorption – eyelids/genitals – 30%, face – 7%, armpits – 4%)	**Potency of steroid (Potential adrenal suppression if potent or very potent)**
Beclometasone dipropionate 0.025%	Potent
Betamethasone dipropionate 0.05% and higher [incl Dalonev, Diprosone, Dovobet, Enstilar; in combination with clotrimazole (incl Lotriderm) and salicylic acid (incl Diprosalic)]	Potent
Betamethasone valerate 0.1% and higher [incl Audovate, Betacap, Betesil, Betnovate, Bettamousse, and in combination with clioquinol, fusidic acid (incl Fucibet, Xemacort) or neomycin]	Potent
Clobetasol propionate 0.05% and higher [incl. Clarelux, ClobaDerm, Dermovate, Etrivex and in combination with neomycin and nystatin]	Clobetasol propionate 0.05% and higher [incl. Clarelux, ClobaDerm, Dermovate, Etrivex and in combination with neomycin and nystatin]
Diflucortolone valerate 0.1% [incl Nerisone]	Potent
Diflucortolone valerate 0.3% [incl Nerisone Forte]	Very Potent
Fluocinonide 0.05% [incl Metosyn]	Potent
Fluocinolone acetonide 0.025% [(incl. Synalar) and in combination with clioquinol (incl Synalar C)]	Potent
Fluticasone propionate 0.05% [incl Cutivate]	Potent
Hydrocortisone butyrate 0.1% [incl Locoid]	Potent
Mometasone 0.1% [incl Elocon]	Potent
Triamcinolone acetonide 0.1% [incl Aureocort]	Potent

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Table 6 - Potent or very potent topical glucocorticoids applied to the rectal or genital areas and used at high dose (more than 30g per month) for more than 4 weeks, and for 12 months after stopping

Rectal treatments	Significant Steroid Dose
Budesonide enema	2mg per dose
Budesonide rectal foam	2mg per dose
Prednisolone rectal solution	20mg per dose
Prednisolone supps	5mg per dose

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Table 7 - Patients prescribed any form of ongoing glucocorticoid treatment (except small amounts of a mild or moderate topical glucocorticoid which should be assessed on a case by case basis) in conjunction with medicines known to be potent CYP3A4 inhibitors

Potent Protease Inhibitors	Atazanavir Darunavir Fosamprenavir Ritonavir (+/- Iopinavir) Saquinavir Tipranavir
Antifungals	Itraconazole Ketoconazole Voriconazole Posaconazole
Antibiotics	Clarithromycin – long term course only

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Appendix 2 – Advice on clinical systems searches

Searches have been produced to assist with identifying patients who may potentially require a steroid emergency card**. It is important to be aware that these searches may not be exhaustive or may bring up patients who may not require a card therefore clinical judgement is still required.** The tables within this guide can support this.

SystmOne Searches

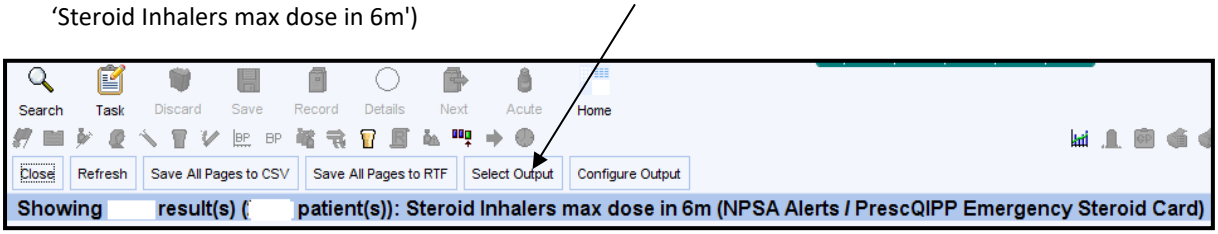
The searches listed below can be found on SystmOne under 'Reporting>Clinical Reporting>Sheffield Practices > NPSA Alerts > PrescQIPP Emergency Steroid Card'.

Steroids oral more than 3 in 12m
Steroids injections more than 2 in 6m
Steroids rectal more than 2 in 6m
Steroid nasal sprays all more than max dose
Steroids eye, ear, nose drops more than 2 in 6 m
Steroid Topical more than 6 in 12m Potent &/ or very potent
Steroid Inhalers max dose in 6m
High dose Steroid with an interacting drug
All High dose (Patients on any high dose steroid)
High dose steroid products patients in 2 steroid reports
High dose steroid products patients in 3 steroid reports
High dose steroid products patients in 4 steroid reports
High dose steroid products patients in 5 steroid reports
High dose steroid products patients in 6 steroid reports
High dose steroid products patients in ALL steroid reports
Steroids Topical potent
Steroids Topical Very potent

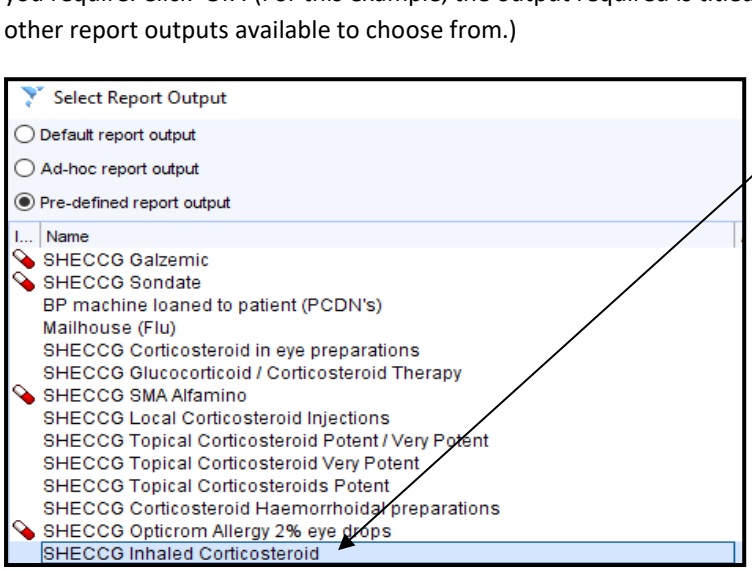
For each of the searches an 'output' has been configured to assist with identifying the steroid preparation and doses prescribed. Instructions on how to access the outputs are provided below:

1. Go to Reporting>Clinical Reporting>Sheffield Practices > NPSA Alerts > PrescQIPP Emergency Steroid Card. Run one of the searches and select 'show patients'. This will take you to the 'Default report output' screen.

2. From the 'Default report output' screen click on 'Select Output'. (The example below is shown for the search titled 'Steroid Inhalers max dose in 6m')



3. The following window will appear. Select 'Pre-defined report output' as shown below and click on the report output you require. Click 'Ok'. (For this example, the output required is titled 'SHECCG Inhaled Corticosteroid' but there will be other report outputs available to choose from.)



4. The search results will now include the details of the last 3 prescriptions issued showing the date of issue, steroid preparation, dose and quantity prescribed

Please remember to change the output back to the default output otherwise this will be the output style used for any other reports you run in SystmOne. To restore the 'Default report output' repeat steps 2 and 3. At step 3 select 'Default report output' and click 'Ok'.

EMIS Web Searches

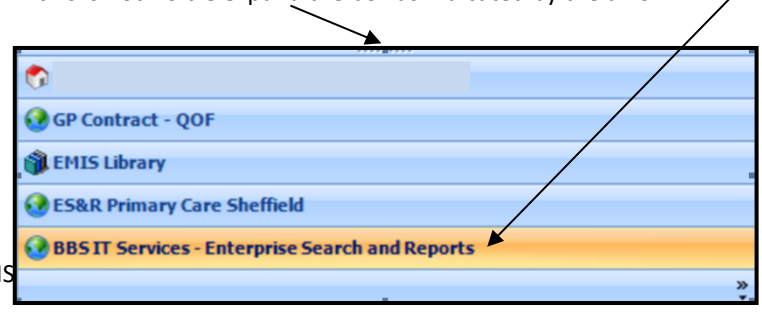
The searches listed below can be found on EMIS Web under 'Population Reporting>BBS IT Services – Enterprise Search and Reports>Sheffield CCG MOT > Medicines Optimisation Team > NPSA Alerts > Steroid Emergency Card Searches EMIS Web'

PrescQIPP Steroid Emergency Card High Dose Steroid combined searches
PrescQIPP Steroid Emergency Card High Dose Steroid with an interacting drug
PrescQIPP Steroid Emergency Card High Dose Steroid Cream Potent
PrescQIPP Steroid Emergency Card High Dose Steroid Cream Very Potent
PrescQIPP Steroid Emergency Card High Dose Steroid Cream Potent or Very Potent
PrescQIPP Steroid Emergency Card High Dose Steroid eye, ear, nose
PrescQIPP Steroid Emergency Card High Dose Steroid inhalers
PrescQIPP Steroid Emergency Card High Dose Steroid injections
PrescQIPP Steroid Emergency Card High Dose Steroid nasal sprays
PrescQIPP Steroid Emergency Card High Dose Steroid rectal treatment
PrescQIPP Steroid Emergency Card High Dose Steroids oral

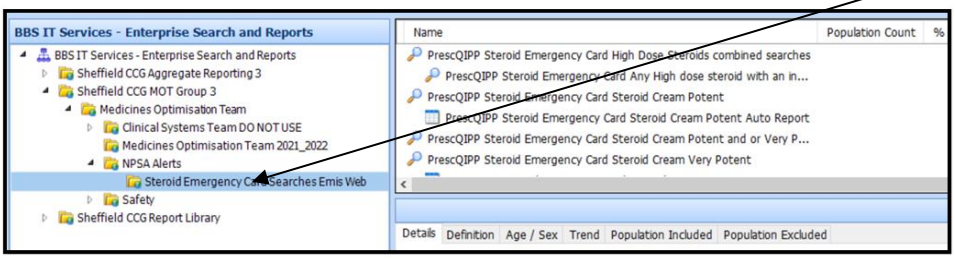
Instructions on how to access the searches are provided below:

1. Go to 'population reporting'

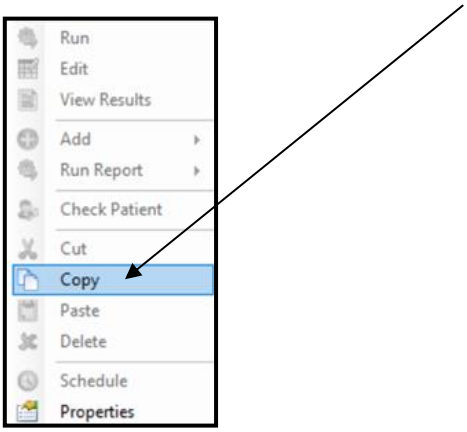
On the bottom left select 'BBS IT Services – Enterprise Search and Reports'.
If this is not visible expand the box as indicated by the arrow.



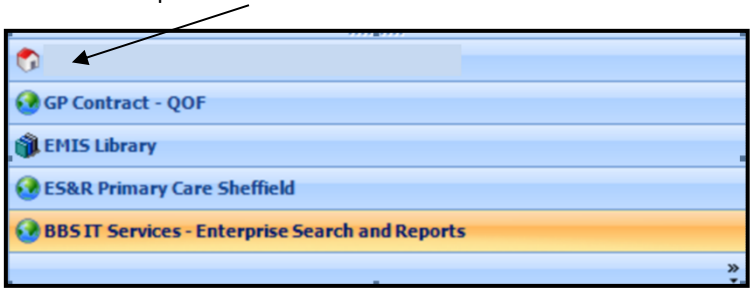
2. Select ‘Sheffield CCG MOT > Medicines Optimisation Team > NPSA Alerts > Steroid Emergency Card Searches Emis Web’



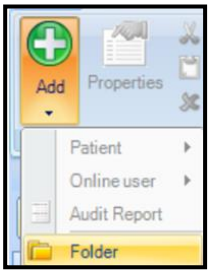
3. Keep the folder title highlighted and select ‘copy’

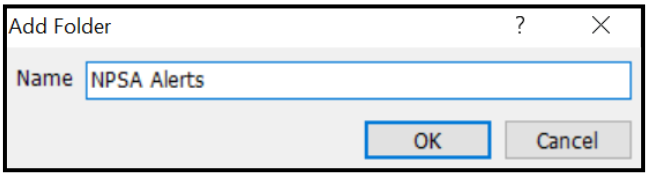


4. Select the practice folder

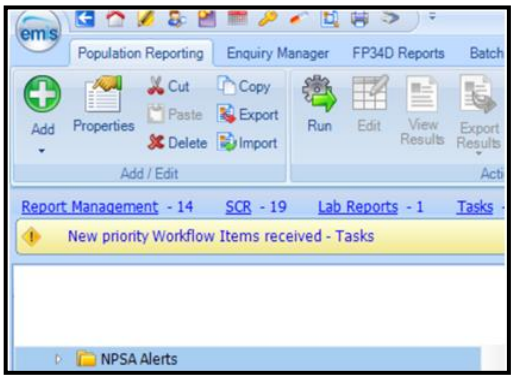


5. Select Add > Folder. Enter the folder name NPSA Alerts > OK





6. Select the File and Press ‘Paste’



7. The searches are now ready to be run. The ‘auto report’ will provide details of the date of issue, steroid preparation, dose and quantity prescribed.