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### Steroid use for patients with brain metastases and spinal cord compression

Editor – I read with interest ‘Brain metastases’ (*Clin Med* 2014;14:535–7) and ‘Metastatic spinal cord compression: a rare but important complication of cancer’ (*Clin Med* 2014;14:542–5). I would like to make a few further points regarding the use of steroids. Spencer *et al* advise high-dose dexamethasone for patients with brain metastases, with a suggested regimen of 16 mg daily, reducing to a maintenance dose of 2–4 mg daily. Dexamethasone provides symptomatic relief for patients with raised intracranial pressure from cerebral oedema but this relief reduces over time and undesirable side effects increase. Thus, ideally, the dose of dexamethasone should be discontinued after 2–4 weeks.<sup>1</sup> No benefit is seen in patients with asymptomatic brain metastases.<sup>2</sup> Robson advises administering 16 mg dexamethasone daily if metastatic cord compression is suspected, but eventual steroid reduction is not discussed. Following radiotherapy or surgery, steroids should be tailed off gradually and completely over 4–6 weeks, or to the lowest dose that maintains stability. Corticosteroids may result in a rapid improvement of neurological function but long-term benefit is limited, and there is no evidence that survival is improved.<sup>3</sup> High-dose, long-duration treatment with corticosteroids causes significant side effects which can be debilitating and occasionally fatal. For those patients who do not proceed to

surgery or radiotherapy, dexamethasone should be reduced gradually and stopped. We undertook an audit of the patients known to St Luke's Hospice in Plymouth in a six-month period this year (n=1,152), and found one-third of them had taken steroids. Oncologists had prescribed steroids in nearly half of cases. 20% of patients were taking steroids for brain metastases and 10% for spinal cord compression. Steroid dose was not regularly reviewed and patients often remained on steroids for far too long, resulting in 40% of patients suffering side-effects, most commonly proximal myopathy and peripheral oedema. 50% of patients were taking steroids until their death. GPs and palliative nurse specialists are often underconfident in reducing and stopping steroid courses and therefore clear guidance needs to be given to indicate duration of steroid course and plans for reduction. ■

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### Response

Editor – My thanks to Dr Murray-Brown for raising this important issue. In my article ‘Metastatic spinal cord compression: a rare but important complication of cancer’ I concentrated primarily on the presentation and initial management of these cases. In the short section on rehabilitation I did not discuss the reduction of steroids and I agree that this is a very important part of the management.

In metastatic spinal cord compression patients the high dose steroids are used to reduce swelling and neurological symptoms whilst they start their definitive treatment. In our practice, once patients have commenced their fractionated radiotherapy treatment we reduce the steroids rapidly by half every two days. Most patients will have stopped taking their steroids just after their discharge on completion of radiotherapy treatment. Occasional patients require longer term treatment to control symptoms but this is kept at the lowest dose possible. If the patient deteriorates on reduction then higher doses are resumed short term to try to improve their symptoms.

I agree that patients who are not fit enough for definitive treatment, or who have received a single fraction of radiotherapy should have their steroids reduced gradually. Ideally they should be reduced gradually and then stopped over a 3–4 week period, or reduced and then maintained at the lowest possible dose at which their symptoms are controlled. ■

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