# COMPLIANCE TO NICE GUIDELINES ON CORTICOSTEROID PRESCRIBING IN AN OPHTHALMOLOGY DEPARTMENT

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## INTRODUCTION

Systemic corticosteroids may be prescribed in a range of Ophthalmic conditions, such as giant cell arteritis, uveitis and inflammatory orbital disease[1]. While highly efficacious, systemic corticosteroids carry significant risks associated with corticosteroid toxicity and hypothalamic-pituitary-adrenal (HPA) axis suppression[2]. Adverse effects are linked to high doses and long-term usage, with adverse effects reported in 90% of patients prescribed corticosteroids for more than 60 days[3]. NICE Guidelines recommend that all patients on corticosteroids should be counselled on adverse effects and symptoms of adrenal insufficiency, and that patients on long-term steroids (>3 weeks duration) or high-dose steroids should be provided with a steroid alert card[4].

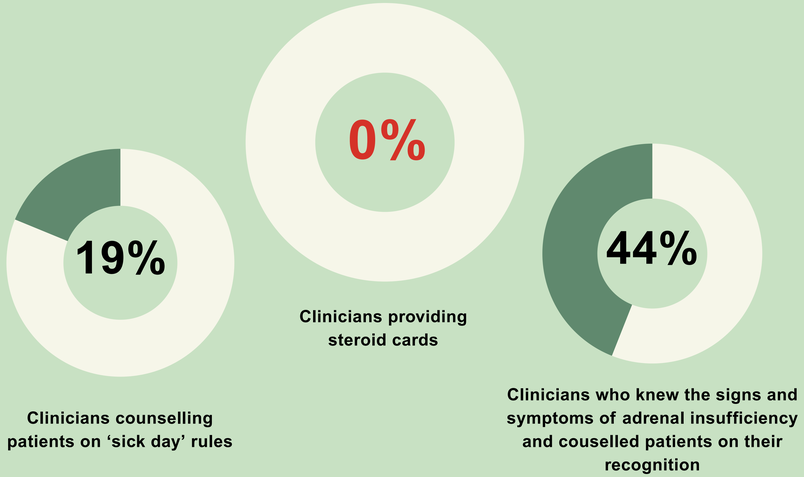
## AIM

This audit aimed to assess compliance to the NICE guidelines on corticosteroid prescribing, to identify areas of knowledge regarding systemic corticosteroid prescribing that clinicians perceive to be deficient, as well as to assess perceived access to relevant resources.

## METHODS

A qualitative cross-sectional audit in the form of an anonymous Likert-scale questionnaire was undertaken in the Ophthalmology Department at the Royal Eye Infirmary in Plymouth. The questionnaire was distributed to all twenty-seven prescribing clinicians in the department. Sixteen responses were received, yielding a response rate of 59%. Data was collected and analysed using simple descriptive statistics.

## RESULTS




75% of clinicians felt confident in their knowledge of the counselling and monitoring requirements, relative and absolute contra-indications and adverse effects of systemic corticosteroids; however, none of the clinicians that responded to the survey were providing patients with a steroid card when prescribing long-term (>3 weeks) systemic corticosteroids.

Only 18.75% of respondents felt confident explaining the need for a steroid card to patients or knew where to access steroid cards, guidelines and patient information leaflets. Less than half of the clinicians surveyed (43.75%) knew the signs and symptoms of adrenal insufficiency, counselled patients on their recognition or knew how to identify patients at risk of HPA axis suppression.

While 62.5% of clinicians agreed or strongly agreed that they ensure patients have clear instructions for seeking emergency medical care if they become acutely unwell, only 18.75% of respondents reported counselling patients on 'sick day rules' for managing corticosteroid use during acute illness.

## DISCUSSION AND CONCLUSION

This audit identified that compliance to NICE guidelines on corticosteroid prescribing in our department is low. None of the clinicians surveyed provided patients with steroid alert cards when prescribing long-term oral corticosteroids. Areas of perceived deficiency in knowledge were identified regarding potentially life-threatening adverse effects such as adrenal insufficiency, with fewer than half of clinicians aware of the signs and symptoms and able to counsel patients on appropriate 'sick day rules'. This represents a potential patient safety risk, leaving patients vulnerable to adrenal insufficiency during periods of acute illness.

In addition, this audit identified a lack of access to steroid alert cards, local guidance and patient information leaflets. We recommend a co-ordinated teaching program be implemented locally to improve knowledge amongst clinicians, in addition to making steroid cards and patient information leaflets easily accessible. Development of local guidelines and referral pathways may also assist clinicians in decision-making.

## ACKNOWLEDGEMENTS AND REFERENCES

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