Care Step Pathway – Hypophysitis (inflammation of the pituitary gland)

Assessment

**Look:**
- Does the patient appear fatigued?
- Does the patient look listless?
- Does the patient look ill?
- Does the patient look uncomfortable?

**Listen:**
- Does the patient report:
  - Change in energy?
  - Headache?
  - Dizziness?
  - Nausea/vomiting?
  - Altered mental status?
  - Visual disturbances?
  - Fever?
  - Changes in libido?

**Recognize:**
- Low levels of hormones produced by pituitary gland (ACTH, TSH, FSH, LH, GH, prolactin)
- Brain MRI with pituitary cuts: enhancement and swelling of the pituitary gland
- Hypotension
- Electrolyte disturbances
- DDX adrenal Insufficiency: low cortisol and high ACTH
- DDX primary hypothyroidism: low free T4 and high TSH

Grading Toxicity (Overall)

**Grade 1 (Mild)**
Asymptomatic or mild symptoms; clinical or diagnostic observation only (headache, fatigue)

**Grade 2 (Moderate)**
Moderate; minimal, local, or noninvasive intervention indicated; limiting age-appropriate instrumental ADLs

**Grade 3 (Severe)**
Severe or medically significant but not immediately life-threatening; hospitalization or prolongation or existing hospitalization indicated; limiting self-care ADLs

**Grade 4 (Potentially Life-Threatening)**
Urgent intervention required (severe ataxia)

**Grade 5 (Death)**

Management

**Overall Strategy:**
- Consider endocrinology consult
- Diagnostic workup should be initiated if not already done: Monitor levels of ACTH, AM cortisol, TSH, T4, and electrolytes
- Additional workup for low libido, mood changes, and fatigue may include LH, FSH, testosterone, and estradiol
- Analgesia as needed for headache (discuss with neurologist if resistant to paracetamol and NSAIDs)
- Ipilimumab to be withheld for any symptomatic hypophysitis and discontinued for symptomatic reactions persisting ≥6 weeks or for inability to reduce steroid dosage to <7.5 mg prednisone or equivalent per day
- Nivolumab to be withheld for Grade 2/3 hypophysitis and permanently discontinued for Grade 4 hypophysitis. Pembrolizumab to be withheld for Grade 2 hypophysitis and withheld or discontinued for Grade 3/4 hypophysitis
  - 1 mg/kg methylprednisolone (or equivalent) IV to be given daily*
    - If given during acute phase, may reverse inflammatory process
    - To be followed with prednisone 1-2 mg/kg daily with gradual tapering over at least 4 weeks
    - May hold checkpoint inhibitors for any symptoms suspect for hypophysitis and restart after stabilized on hormone therapy
    - Long-term supplementation of affected hormones is often required
    - Secondary hypothyroidism requiring levothyroxine replacement
    - Secondary hypoadrenalism requiring hydrocortisone replacement
      - Typical dosage: 20 mg qAM and 10 mg qPM
      - Steroids should start several days prior to any thyroid replacement to prevent adrenal crisis
    - Assess risk of opportunistic infection based on duration of steroid taper (and consider prophylaxis if needed)
    - Collaborative management approach with endocrinology (particularly if permanent loss of organ function)
    - Medical alert bracelet is indicated

Implementation:
- ACTH and thyroid panel should be checked at baseline and prior to each dose of ipilimumab
- Ensure that MRI is ordered with pituitary cuts or via pituitary protocol
- Anticipate treatment with corticosteroid and immunotherapy hold
- Review proper administration of steroid
  - Take with food
  - Take in AM
- Educate patient regarding possibility of permanent loss of organ function (pituitary; possibly others if involved [thyroid, adrenal glands])
- Advise patients about medical alert bracelet, etc., stress doses of hydrocortisone or infection, etc.

*Administering Corticosteroids:*

Steroid taper instructions/calendar as a guide but not an absolute
- Taper should consider patient’s current symptom profile
- Close follow-up in person or by phone, based on individual need & symptomatology
- Steroids cause indigestion; provide antacid therapy daily as gastric ulcer prevention while on steroids (e.g., proton pump inhibitor or H2 blocker if prednisone dosage is >20 mg/day)
- Review steroid medication side effects: mood changes (angry, reactive, hyperactive, euphoric, manic), increased appetite, interrupted sleep, oral thrush, fluid retention
- Be alert to recurring symptoms as steroids taper down & report them (taper may need to be adjusted)

Long-term high-dose steroids:
- Consider antimicrobial prophylaxis (sulfamethoxazole/trimethoprim double dose MW/F; single dose if used daily) or alternative if sulfa-allergic (e.g., atovaquone [Mepron®] 1500 mg po daily)
- Consider additional antiviral and antifungal coverage
- Avoid alcohol/acetaminophen or other hepatotoxins
- If extended steroid use, risk for osteoporosis; initiate calcium and vitamin D supplements

**RED FLAGS:**
- Symptoms of adrenal insufficiency
- New onset of severe headache or vision changes

ACTH = adrenocorticotropic hormone; ADLs = activities of daily living; DDX = differential diagnosis; FSH = follicle-stimulating hormone; GH = growth hormone; LH = luteinizing hormone; MRI = magnetic resonance imaging; po = by mouth; TSH = thyroid stimulating hormone.

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