Prednisolone

Prednisolone is normally reduced according to the following schedule:

20 mg	x	1 month started on day 2
15mg	x	1 month
10 mg	x	1 month
5 mg	x	thereafter

At 3 months to remain on minimum of 5 mg or 7.5 mg if >75 kg in weight. Generally patients remain on maintenance dose until the end of the first year and then review.

At one year, cessation of Prednisolone may be considered (See steroid withdrawal protocol)

NB caution should be exercised in patients with an increased risk of rejection.

All patients to receive Ranitidine (150 mgs od) along with Prednisolone.

This schedule may be altered if rejection occurs.

Increased Risk for Steroid withdrawal:

- Level of HLA mismatching, particularly HLA-DR and DQ
- > 2 transplants
- highly sensitised patients
- Rejection episodes > 1 or more acute rejection episodes Banff grade > II
- De-novo proteinuria
- Late acute rejection i.e. occurring after 6 months. In this case, steroid withdrawal is not recommended and, if indicated, should only be undertaken after renal biopsy has confirmed no ongoing inflammation or rejection.

Steroid withdrawal

Steroid withdrawal should be discussed with the patient and they should be informed of the risk of rejection.

The steroids should be withdrawn according to the following schedule:

- Decrease by 1 mg per month till 0 mg
- The patient requires monthly blood for creatinine

Steroid induced osteoporosis

All patients should receive additional elemental calcium, this may be as one or two tablets per day depending on dietary intake.

- If GFR >30 mls/min Calcichew D3 Forte should be used (2 tabs).
- If GFR < 30 mls/min Alfacalcidol and Calcichew should be used.

HRT should be used in individuals at risk of osteoporosis (unless patient has a contra-indication to HRT).
All patients should be given advice on diet, weight, exercise, smoking cessation, skin surveillance.