SPEAKER: As far as corticosteroid taper in acute and chronic GvHD, there are very different ways of doing it and actually no standard proved way of tapering off prednisone. The more common approach for acute graft versus host disease is, as I said, start with 2 milligrams per kilogram per day of methylprednisolone or prednisone equivalent. Usually we start with methylprednisolone intravenously. And the dose is almost always kept at 1 [INAUDIBLE] per kilo or more of methylprednisolone per day up until day 14 of treatment.

So basically, for the first 14 days, we go from 2 to 1 milligram per kilogram per day without going under 1 milligram per kilogram per day. That's actually relatively standard in all different tapering schedules for acute graft versus host disease. From there on, people tend to taper by approximately 20% of the dose weekly, up until 20 milligrams daily. That is when you start the tail end of the taper, where we tend to slow down. Usually when there are reflares, they tend to occur at this tail end of the taper.

And that is what I do in my practice. It does not mean is the standard thing to do or the right thing to do. But that is what I find that a lot of different centers use as a general guideline.

Second, with chronic graft versus host disease, it gets probably a little more complicated. But normally, we want to start the steroid taper when we see some degree of response to therapy. So we initiate 1 milligram per kilogram per day of prednisone. Most places will keep the patient on this 1 milligram per kilogram per day of prednisone for approximately 10 to 14, 15 days and then initiate taper after that if the patient had some degree of response at two weeks.

Now, the speed of taper from there on truly depends on patient response to therapy. So it's difficult to talk about percentage of the dose without, you know, knowing in parallel how the patient is responding to the prednisone.