Supplementary Appendix

Appendix 1. The Likert scale and definitions of consensus used throughout the Delphi process.

![Likert Scale Diagram]

-5 -4 -3 -2 -1 0 1 2 3 4 5
Strongly disagree Neither agree nor disagree Strongly agree
Consensus Against No consensus Consensus For
Neither agree nor disagree

**Appendix 2. RCI Treatment Algorithm Delphi Questionnaire 3 Results**

This table contains the questions from the third Delphi questionnaire, the mean and standard deviation of the Likert scale results, and whether consensus was reached or not reached.

| Delphi Statement/Question | Mean | Std Dev | Consensus |
|---------------------------|------|---------|-----------|
| **DOSING**                |      |         |           |
| Since repository corticotrophin injection (RCI) dosing is typically 40–80 units delivered by either intramuscular or subcutaneous injection every 24–72 hours, it is possible to individualize the dosage according to the patient’s medical condition as well as disease severity. |      |         |           |
| **Initiating Therapy**    |      |         |           |
| 1. For most pulmonary sarcoidosis patients, the initial RCI dose should be |      |         |           |
| 1a. 80U sq q72h            | −0.4 | 2.6     | No        |
| 1b. 80U twice weekly       | 1.4  | 2.6     | No        |
| 1c. 40U daily, titrated down if response occurs | −2.1 | 2.2 | No |
| 1d. 40U three times weekly | 0.3  | 2.9     | No        |
| 1e. 40U sq q72h            | 1.0  | 3.0     | No        |
| 1f. 40U twice weekly       | 3.0  | 2.1     | For       |
| 2. General dosing issues   |      |         |           |
| 2a. Most patients with less active disease should receive a lower initial RCI dose, eg 40U twice weekly | 2.7  | 2.3     | For       |
| 2b. Most patients with more active disease should receive a higher initial RCI dose, eg 80U twice weekly | 1.1  | 3.1     | No        |
| 2c. The initial RCI dose should be determined based on patient body weight | −0.3 | 2.4 | No |
| 3. For patients who have had concerning adverse reactions to other medications, the dose should be decreased to 40U twice weekly | 1.3  | 2.4     | No        |
| 4. For patients with ocular sarcoidosis, the initial RCI dose should be 80U twice weekly | 1.8  | 2.2     | No        |
| 5. A loading dose is needed when initiating RCI | −1.5 | 2.8 | No |
| **Maintenance Therapy**   |      |         |           |
| 6. RCI should be continued as a maintenance dose for most patients who respond to RCI | 3.2  | 1.8     | For       |
| 7. RCI should be continued at a maintenance dose for patients with chronic refractory sarcoidosis who respond to RCI | 3.5  | 1.7     | For       |
| 8. The maintenance dose should be determined individually for each patient | 3.2  | 1.5     | For       |
9. The maintenance dose should be determined by starting at a low RCI dose (eg 40U twice weekly) and titrating up until satisfactory response is achieved

10. The maintenance dose should be determined by starting at a high RCI dose and titrating down to the lowest effective dose

| Concomitant Steroids |
|----------------------|
| 11. In patients receiving RCI and concomitant steroids, steroids should be tapered or weaned |
| 12. Weaning or tapering of steroids should be done as rapidly as possible |
| 13. Weaning or tapering of steroids should be started 2-3 months after initiation of RCI |

| RCI Dose Reduction or Discontinuation |
|--------------------------------------|
| 14. The RCI dose should be reduced or discontinued if |
| 14a. Excessive RCI-related toxicity develops |
| 14b. Significant oedema develops |
| 14c. Hyperglycaemia and/or diabetic complications develop |
| 14d. Infection develops |
| 14e. Psychiatric adverse events occur (eg suicidal thoughts, agitation, psychosis) |
| 14f. Major steroid side effects develop (eg cushingoid features, increased pigmentation) |
| 14g. RCI-related costs are excessive |
| 14h. Response to RCI is lost (symptoms or signs progress after an initial response) |
| 14i. RCI is ineffective in achieving goals of therapy |

| Weaning RCI |
|-------------|
| 15. RCI should be considered ineffective if symptoms or signs do not improve |
| 15a. Within 1-2 months |
| 15b. Within approximately 3 months |
| 15c. Within 3-6 months |
| 15d. Within 12 months |

| 16. The patient should be weaned from RCI if: |
| 16a. The disease is stable and well-controlled for 3-6 months |
| 16b. The disease is stable and well-controlled for 6-12 months |
| 16c. The disease is stable and well-controlled for 1-3 months |
17. RCI should be weaned by decreasing the dosing frequency, then decreasing the dose, then stopping
18. RCI should be weaned by gradually decreasing the dose, then stopping
19. Weaning RCI by decreasing the frequency, then decreasing dose is preferable to weaning by just decreasing the dose

**Route of Administration**

20. For most patients, RCI should be administered by subcutaneous injection
21. RCI may be administered by intramuscular injection if subcutaneous injection fails

**Testing and Dosing in Special Populations**

22. The following tests should be done (or recent results should be available) before initiating RCI:

| Test Description                                      | Value1 | Value2 | Note |
|--------------------------------------------------------|--------|--------|------|
| 22a. Complete blood count (CBC)                        | 2.7    | 2.3    | For  |
| 22b. Comprehensive metabolic panel (CMP)               | 3.3    | 2.4    | For  |
| 22c. Liver function tests                              | 2.5    | 2.9    | No   |
| 22d. HbA1C levels                                     | 2.3    | 1.9    | No   |
| 22e. Bone density scan (DEXA)                         | 2.8    | 1.7    | For  |
| 22f. Tuberculosis                                     | 2.2    | 2.8    | No   |
| 22g. Hepatitis B and C                                | 1.7    | 2.8    | No   |
| 22h. HIV                                               | 0.8    | 2.9    | No   |
| 22i. TSH                                               | 1.8    | 2.7    | No   |

23. Tuberculosis screening before initiating RCI can use the following test(s):

| Test Description                                      | Value1 | Value2 | Note |
|--------------------------------------------------------|--------|--------|------|
| 23a. No specific screening is required                  | 0.8    | 3.2    | No   |
| 23b. Screening is only needed if the patient has risk factors, eg history of TB, history of TB exposure, or on relevant concomitant medications | 1.0    | 2.7    | No   |
| 23c. Close monitoring with no specific test            | 0.3    | 2.7    | No   |
| 23d. Tuberculin                                        | −0.2   | 2.9    | No   |
| 23e. Interferon gamma                                  | 0.2    | 3.6    | No   |
| 23f. Quantiferon Gold                                  | 2.1    | 2.9    | No   |
| 23g. Chest x-ray                                       | 1.5    | 3.1    | No   |
| 23h. Please list any other appropriate TB screening tests | −1.1   | 2.4    | No   |
| 23i. No specific screening is required                 | −1.0   | 3.1    | No   |

24. The following conditions are contraindications to RCI:

| Condition                                             | Value1 | Value2 | Note |
|-------------------------------------------------------|--------|--------|------|
| 24a. Latent TB                                         | 1.3    | 2.2    | No   |
| 24b. Hypothyroidism                                   | −0.7   | 2.6    | No   |
| Condition                                                                 | Score | Duration | Action   |
|---------------------------------------------------------------------------|-------|----------|----------|
| 24c. Decompensated cirrhosis                                              | 1.1   | 2.7      | No       |
| 24d. Any cirrhosis                                                        | −0.5  | 2.3      | No       |
| 24e. Primary adrenocortical insufficiency                                 | 2.3   | 1.7      | No       |
| 24f. Adrenocortical hyperfunction                                         | 1.9   | 2.2      | No       |
| 24g. Untreated osteoporosis                                               | 1.1   | 2.2      | No       |
| 24h. Any osteoporosis                                                    | −0.2  | 2.6      | No       |
| 24i. Uncontrolled systemic fungal infection                               | 4.0   | 1.4      | For      |
| 24j. Any systemic fungal infection                                        | 2.5   | 1.7      | No       |
| 24k. Uncontrolled ocular herpes simplex infection                         | 3.8   | 1.4      | For      |
| 24l. Any ocular herpes simplex infection                                  | 2.1   | 2.4      | No       |
| 24m. Recent surgery                                                       | 0.4   | 2.5      | No       |
| 24n. Treated/controlled peptic ulcer                                      | −1.2  | 2.4      | No       |
| 24o. Any peptic ulcer                                                     | −0.2  | 2.2      | No       |
| 24p. Decompensated / uncontrolled congestive heart failure                | 1.8   | 2.0      | No       |
| 24q. Any congestive heart failure                                         | 0.0   | 2.0      | No       |
| 24r. Uncontrolled hypertension                                            | 1.0   | 2.4      | No       |
| 24s. Any hypertension                                                    | −1.2  | 2.2      | No       |
| 24t. Scleroderma                                                          | 0.8   | 3.2      | No       |
| 24u. Sensitivity to proteins of porcine origin                            | 3.8   | 1.5      | For      |
| 24v. Severe or brittle diabetes                                           | 2.9   | 1.7      | For      |
| 24w. Insulin requiring diabetes                                           | 1.3   | 2.1      | No       |
| 24x. Patient difficulty with or dislike of self-injection                 | 1.7   | 2.1      | No       |
| 24y. Pre-existing osteoporosis and hypertension are acceptable if monitored and the patient is on medication for these conditions | | | |

**Adverse Effect Management**

Effective management of the adverse events (AE) associated with RCI is important to promote adherence and thereby improve outcomes. However, little or no published guidance on AE management is available. This portion of the questionnaire focuses on the prevention and management of common and/or important RCI-related adverse events.

Note that many AEs associated with RCI, particularly near the time of RCI administration, are similar to those associated with high-dose steroids. In answering the following questions, please focus on RCI-specific AEs.

**Oedema**

25. Non-Pharmacological Management of new/worsening oedema should include

| Action                                          | Score | Duration | Action   |
|-------------------------------------------------|-------|----------|----------|
| 25a. Evaluate/diagnose potential causes          | 4.4   | 1.4      | For      |
| 25b. Limit salt intake                          | 4.0   | 1.5      | For      |
25c. Elevation 3.7 1.4 For

26. Pharmacological Management of new/worsening oedema should include
   26a. Initiate diuretics 3.6 1.6 For
   26b. Loop diuretics (Lasix, etc.) 2.9 1.9 For
   26c. Spironolactone (Aldactone) 2.8 1.9 For

27. RCI Dose Adjustment
   27a. Dose down titration after pharmacological and non-pharmacological interventions fail 3.6 1.4 For
   27b. Dose down titration concomitant to pharmacological and non-pharmacological interventions due to severity of AE 2.9 1.6 For
   27c. Medication discontinuation if other interventions fail 3.0 2.4 For
   27d. Medication discontinuation if AE is severe and significant 4.3 1.5 For
   27e. Re-up titration or resumption of medication at lower dose once symptoms resolve 2.4 1.7 No

Anxiety/Depression

28. Non-Pharmacological Management of new/worsening anxiety/depression should include
   28a. Refer to PCP/psychiatry 2.7 2.6 For

29. Pharmacological Management of new/worsening anxiety/depression should include
   29a. Anxiolytic therapy 1.0 1.6 No
   29b. Anti-depressant therapy (eg SSRI) 1.8 1.8 No
   29c. Antipsychotic medication −0.7 2.3 No

30. RCI Dose Adjustment
   30a. Dose down titration after pharmacological and non-pharmacological interventions fail 3.5 1.6 For
   30b. Dose down titration concomitant to pharmacological and non-pharmacological interventions due to severity of AE 3.5 1.6 For
   30c. Medication discontinuation if other interventions fail 4.1 1.6 For
   30d. Medication discontinuation if AE is severe and significant 4.3 1.5 For
   30e. Re-up titration or resumption of medication at lower dose once symptoms resolve 0.7 2.7 No

Infection

31. Pharmacological Management of Infection should include
   31a. First-line treatment of the specific infection 4.4 1.5 For
31b. Second-line treatment of the specific infection 3.5 1.7 For
31c. Switch to IV steroid from Acthar gel −0.5 2.0 No
31d. Steroids are only used if there is concern about adrenal insufficiency or patient had severe organ (life threatening) disease 1.9 1.7 No

32. RCI Dose Adjustment

32a. Dose down titration after pharmacological interventions fail 2.4 3.0 No
32b. Dose down titration concomitant to pharmacologic interventions due to severity of AE 3.8 1.5 For
32c. Medication discontinuation if other interventions fail 3.9 1.5 For
32d. Medication discontinuation if AE is severe and significant 4.2 1.5 For
32e. Re-up titration or resumption of medication at lower dose once symptoms resolve 2.3 2.0 No

Increased appetite/weight gain

33. Non-Pharmacological Management if the patient develops increased appetite and weight gain should include

33a. Behavioural intervention 4.3 1.5 For
33b. Dietary counselling 4.2 1.5 For
33c. Exercise program 4.1 1.4 For
33d. Pulmonary rehabilitation 3.5 1.9 For

34. Pharmacological Management if the patient develops increased appetite and weight gain should include

34a. First line—Appetite suppressants −0.5 3.5 No
34b. Second line—Appetite suppressants −1.3 3.1 No
34c. Shorten the counselling interval 0.4 3.5 No

35. RCI Dose Adjustment

35a. Dose down titration after pharmacological and non-pharmacological interventions fail 2.9 1.6 For
35b. Dose down titration concomitant to pharmacologic and non-pharmacological interventions due to severity of AE 3.4 1.8 For
35c. Medication discontinuation if other interventions fail 3.3 1.7 For
35d. Medication discontinuation if AE is severe and significant 4.0 1.5 For
35e. Re-up titration or resumption of medication at lower dose once symptoms resolve 1.6 1.6 No

Glucose intolerance/worsening in glucose control
36. Pharmacological Management if the patient develops glucose intolerance/worsening in glucose control should include

36a. Manage glucose with metformin 2.3 1.5 No
36b. Manage glucose with insulin 2.3 1.4 No
36c. Manage glucose with other oral agents 2.2 1.3 No
36d. Same as with oral steroids 3.0 1.4 For

37. RCI Dose Adjustment

37a. Dose down titration after pharmacological interventions fail 3.1 1.3 For
37b. Dose down titration concomitant to pharmacologic interventions due to severity of AE 3.1 1.6 For
37c. Medication discontinuation if other interventions fail 3.0 1.7 For
37d. Medication discontinuation if AE is severe and significant 3.9 1.6 For
37e. Re-up titration or resumption of medication at lower dose once symptoms resolve 1.8 1.8 No

Hypertension

38. Non-Pharmacological Management if the patient develops hypertension should include

38a. Educate on sodium and fluids 4.3 1.4 For
38b. Refer to PCP 3.5 1.9 For

39. Pharmacological Management if the patient develops hypertension should include

39a. First line—Antihypertensive medication 3.7 1.5 For
39b. Second line—Add or increase antihypertensive medication 3.1 1.3 For

40. RCI Dose Adjustment

40a. Dose down titration after pharmacological and non-pharmacological interventions fail 3.1 1.6 For
40b. Dose down titration concomitant to pharmacologic and non-pharmacological interventions due to severity of AE 3.6 1.4 For
40c. Medication discontinuation if other interventions fail 3.3 1.5 For
40d. Medication discontinuation if AE is severe and significant 3.8 1.7 For
40e. Re-up titration or resumption of medication at lower dose once symptoms resolve 1.7 1.7 No

Darkening of the Skin

41. Non-pharmacological and pharmacological management if the patient develops darkening of the skin should include
41a. Counselling for patient 41b. Topical skin therapies

42. RCI Dose Adjustment

42a. Dose down titration after pharmacological and non-pharmacological interventions fail 42b. Dose down titration concomitant to pharmacologic and non-pharmacological interventions due to severity of AE

42c. Medication discontinuation if other interventions fail 42d. Medication discontinuation if AE is severe and significant

42e. Re-up titration or resumption of medication at lower dose once symptoms resolve

Other Skin-related AEs

43. Non-pharmacological interventions if the patient develops other skin-related AEs should include

43a. Refer to dermatology 43b. Counselling; encourage patient to complete the course of therapy

43c. Rotate the injection site

44. Pharmacological interventions if the patient develops other skin-related AEs should include

44a. First line—topical skin therapies 44b. Second line—reduce RCI dose or frequency

44c. Refer to dermatology

45. RCI Dose Adjustment

45a. Dose down-titration after pharmacological and non-pharmacological interventions fail 45b. Dose down titration concomitant to pharmacologic and non-pharmacological interventions due to severity of AE

45c. Medication discontinuation if other interventions fail 45d. Medication discontinuation if AE is severe and significant

45e. Re-up titration or resumption of medication at lower dose once symptoms resolve

Localized injection site pain

46. Non-pharmacological management for localised injection site pain should include

46a. Cool skin with an ice pack
46b. Rotate injection sites
46c. Slower injection rate
46d. Educate on injection technique
46e. Massage the area

47. Pharmacological management for localised injection site pain should include

| 47a. Local anaesthetics (lidocaine/EMLA) | 47b. Ibuprofen |
|------------------------------------------|---------------|
| 0.7                                      | 2.2           |

48. RCI Dose Adjustment

48a. Dose down titration after pharmacological and non-pharmacological interventions fail
48b. Dose down titration concomitant to pharmacologic and non-pharmacological interventions due to severity of AE
48c. Medication discontinuation if other interventions fail
48d. Medication discontinuation if AE is severe and significant
48e. Re-up titration or resumption of medication at lower dose once symptoms resolve

Insomnia

49. Non-pharmacological management for insomnia should include

| 49a. Sleep hygiene | 49b. Mindfulness techniques/meditation |
|-------------------|--------------------------------------|
| 4.2               | 4.0                                  |

50. Pharmacological management for insomnia should include

| 50a. OTC (eg Benadryl, melatonin) | 50b. Ambien (zolpidem) | 50c. Remeron (mirtazapine) | 50d. Trazodone | 50e. Lunesta (eszopiclone) | 50f. Klonopin (clonazepam) | 50g. Antidepressant or anxiolytics depending on symptoms | 50h. Integrative medicine |
|----------------------------------|------------------------|---------------------------|---------------|---------------------------|--------------------------|------------------------------------------------|-------------------------|
| 3.5                              | 1.8                    | 2.0                       | 1.1           | 1.3                       | 0.6                      | 0.8                                          | 3.0                     |

51. RCI Dose Adjustment

51a. Dose down-titration after pharmacological and non-pharmacological interventions fail
51b. Dose down-titration concomitant to pharmacologic and non-pharmacological interventions due to severity of AE
| 51c. Medication discontinuation if other interventions fail | 2.8 | 2.0 | For |
| 51d. Medication discontinuation if AE is severe and significant | 3.6 | 1.7 | For |
| 51e. Re-up titration or resumption of medication at lower dose once symptoms resolve | 1.8 | 1.9 | No |

**Concomitant immunosuppressive medications**

**52. Management of concomitant immunosuppressive medications should include**

| 52a. Monitor as when using steroids | 3.8 | 1.5 | For |
| 52b. Standard of care with the appropriate laboratory and adverse effect management | 4.5 | 1.5 | For |
| 52c. Continue methotrexate or Imuran | 4.0 | 1.5 | For |
| 52d. Attempt to reduce dose as tolerated; starting with prednisone, then other immunosuppressive medications, then RCI | 2.3 | 2.3 | No |
| 52e. Use RCI to maintain immunosuppression until a concomitant immunosuppressant is on board | 3.1 | 1.5 | For |
| 52f. Decrease immunosuppressant dose if possible depending on which medications are used | 2.6 | 1.8 | For |
| 52g. Keep DMARDs unchanged while taking RCI | 3.2 | 1.6 | For |
| 52h. Maintain dosage unless and until goals are met | 3.5 | 1.4 | For |
| 52i. Decrease the dose of concomitant medications | 0.1 | 2.6 | No |

**53. RCI Dose Adjustment**

| 53a. Dose down titration after concomitant immunosuppressive medications fail | 0.6 | 2.5 | No |
| 53b. Dose down titration concomitant to immunosuppressive medications due to severity of AE | 2.0 | 2.3 | No |
| 53c. Medication discontinuation if concomitant immunosuppressive medications fail | 0.3 | 2.5 | No |
| 53d. Medication discontinuation if AE is severe and significant | 3.1 | 1.6 | For |
| 53e. Re-up titration or resumption of medication at lower dose once symptoms resolve | 1.8 | 1.5 | No |

**Hospitalisation**

**54. Management when patients are hospitalised should include**

| 54a. Ensure patient receives steroids at a stress dose | 3.1 | 1.9 | For |
| 54b. Hold RCI dose | 0.8 | 2.6 | No |
| 54c. Continue RCI | 0.4 | 3.2 | No |
| Continue RCI unless hospitalisation is for | −0.7 | 4.0 | No |
| 54d. Infection | 1.5 | 3.1 | No |
54e. Life-threatening infection 3.4 3.0 For
54f. Heart failure 1.7 3.3 No
54g. Hyperglycaemia 1.8 3.3 No
54h. Surgery 1.1 3.3 No
54i. Sepsis 3.2 2.9 For
54k. Continue to hold RCI until discharge 0.7 3.6 No
54l. Hold RCI if any questionable RCI-related cause 3.3 2.9 For
54m. Stop RCI if needed due to severe exacerbations such as neurosarcoidosis related issues 2.3 2.4 No

### Treatment Practice-specific questions

Note: these questions did not seek consensus

Of the patients with pulmonary sarcoidosis you have treated with RCI,

55. What percent were started on RCI because of **intolerance** to steroids, cytotoxic agents or biologics?
   30% 25.41

56. What percent (%) were started on RCI as **second line** to steroids?
   36% 37.47

57. What percent (%) were started on RCI as **third line**: Combination of steroids **AND** cytotoxic agents failed?
   28% 21.62

58. What percent were started on RCI as **third line: Combination** of steroids **AND** biologics failed?
   16% 13.90

59. What percent were started on RCI as **fourth line** therapy: Combinations of steroids/cytotoxics and biologics, tried and failed?
   14% 14.00

60. When treating for pulmonary sarcoidosis with steroids, cytotoxic agents and biologics, how have you typically paired RCI in combination with these agents?
   - Yes
   - Usually RCI instead of biologic
   - Just added on, then starting tapering steroids rather quickly
   - Determine whether patient is benefiting from the combination of drugs. Usually RCI is for advanced, refractory patients.
   - RCI+cytotoxic agents
   - Steroids, then MTX, then RCI or infliximab
   - Have not used this pairing
   - If concerned patient constitution not robust enough for steroids, eg HIV, myositis with fear of not weaning from steroids rapidly etc. Steroids and steroid type medications are for quick onset to quell a fire and with simultaneous transition to steroid-sparing agent.
   - Similar to corticosteroid use, I pair with MTX or azathioprine or even infliximab.
   - Often start the RCI and wean the others
   - I start 40 twice weekly in addition to the current steroid dose and MTX or others, I uptitrate the dose if the BP and blood sugar are maintained
• No specific pairings

61. Are there any patient populations or treatment settings where RCI may be appropriate to use concomitantly?

• Most patients using cytotoxic agents as sole therapy may benefit from RCI therapy as concomitant meds
• Patients failing biologics but who still have evidence for inflammation (e.g. positive PET scan)
• Refractory sarcoidosis with progressive decline
• Severe systemic disease such as patients with eye, lung, liver and spleen and bone involvement
• Probably, I just have not
• Concomitantly with steroids? No, only when trying to wean steroids. We don't have these answers yet. I use in HIV patients mostly instead of steroids though there is no good data for this- just hoping for a better, more protective outcome - but it's been a long time
• Not sure
• Severe progressive sarcoidosis
• Appropriate treatment of refractory disease
Appendix 3. Consensus recommendations for managing concomitant immunosuppressive medications in patients receiving RCI as therapy for pulmonary sarcoidosis.

**Management strategy**

| Management strategy                                                                 | Mean | Std Dev |
|-------------------------------------------------------------------------------------|------|---------|
| Management of concomitant immunosuppressive medications should include              |      |         |
| Monitor as when using steroids                                                      | 3.8  | 1.5     |
| Standard of care with the appropriate laboratory and adverse effect management       | 4.5  | 1.5     |
| Continue methotrexate or azathioprine                                              | 4.0  | 1.5     |
| Attempt to reduce dose as tolerated; starting with prednisone, then other immunosuppressants | 2.3  | 2.3     |
| Use RCI to maintain immunosuppression until a concomitant immunosuppressant is on board | 3.1  | 1.5     |
| Decrease immunosuppressant dose if possible depending on which medications are used | 2.6  | 1.8     |
| Keep DMARDs unchanged while taking RCI                                              | 3.2  | 1.6     |
| Maintain dosage unless and until goals are met                                      | 3.5  | 1.4     |
| Decrease the dose of concomitant medications                                       | 0.1  | 2.6     |

Mean Delphi Score
Appendix 4. Consensus recommendations for contraindications to RCI therapy in pulmonary sarcoidosis.

| Contraindication                                           | Mean | Std Dev |
|------------------------------------------------------------|------|---------|
| Severe or brittle diabetes                                 | 2.9  | 1.7     |
| Uncontrolled fungal infection                              | 4.0  | 1.4     |
| Uncontrolled ocular herpes simplex virus infection         | 3.8  | 1.4     |
| Sensitivity to porcine proteins                            | 3.8  | 1.5     |

![Graph showing mean Delphi scores for contraindications]
Appendix 5. Consensus recommendations for use of RCI as therapy for pulmonary sarcoidosis in hospitalised patients.

| Statement                                           | Mean | Std Dev |
|-----------------------------------------------------|------|---------|
| Management of hospitalised patients should include: |      |         |
| Hold RCI if any questionable RCI-related cause      | 3.3  | 2.9     |
| Ensure patient receives steroids at a stress dose   | 3.1  | 1.9     |
| Continue RCI unless hospitalisation is for:         |      |         |
| Life-threatening infection                           | 3.4  | 3.0     |
| Sepsis                                              | 3.2  | 2.9     |

Mean Delphi Score

![Chart showing mean and standard deviation of Delphi scores for different statements regarding RCI therapy for pulmonary sarcoidosis in hospitalised patients.](chart.png)