PREVENTION OF ADRENAL CRISIS

Patients at Risk of Adrenal Crisis

[Not exhaustive; see Society of Endocrinology Guidelines]

Primary AI: Addison’s disease, congenital adrenal hyperplasia, bilateral adrenalectomy, bilateral adrenal haemorrhage, bilateral adrenal metastases

Secondary/Tertiary AI:
- Pituitary disease, hypothyroidism, pituitary damage from tumours or surgery, drug-induced, exogenous steroids (see page 2 for patients at risk)

Risk increased during intercurrent illness, surgery, childbirth or interruption in glucocorticoid replacement therapy

Severe intercurrent illness (e.g. persistent vomiting, sepsis), acute trauma. Follow MANAGEMENT of Adrenal Crisis box

Peri-operative management

[for detailed peri-operative guidelines and use Epic SmartPhrase]

- All patients at risk of AI should be given extra glucocorticoid when undergoing surgery or an invasive diagnostic procedure.
- Consider 20mg IV hydrocortisone (or equivalent) for all AI patients in order to minimise fasting or dehydration
- Liaise with the Endocrine team when planning elective surgery, and when caring for post-surgical cases.

Use ‘Adrenal Crisis’ order set on Epic

- Hydrocortisone (sodium succinate) 100 mg IV (or IM), followed by:
  - 50 mg IV or IM 6 hours, or 200 mg over 24 continuous IV infusion (if practical to do)
- Patients can be discharged:
  - If discharged (<800mg/day) restate with boluses of sodium chloride 0.9% (250-500ml over 15 minutes)
  - Check sodium first for 2 weeks (Table 6)
- Senior IV/ICU review if not responding

If haemodynamically unstable rehydrate with IV fluids or as clinically appropriate

Monitoring

U&ST, strict fluid balance, cardiac monitoring (consider ICU transfer). Extra care if pulmonary/hypothyroidic or diabetes insipidus (ensure desmopresin is given)