Adrenal Insufficiency Crisis– 10.015

PURPOSE:

Adrenal Insufficiency Crisis is the inability to cope with shock due to lack of appropriate cortisol production. It can occur from stress secondary to medical or trauma etiologies. Patient will likely have a known history of Addison's Disease, Adrenal Tumors, Adrenal Insufficiency, or Congenital Adrenal Hypo/Hyperplasia. Patients will be on replacement medications (Hydrocortisone, Fluticortisone, Methylprednisolone) on a daily basis. Look for medical alert bracelets/pendants. Patient/family will likely be well versed in their condition and may have a Hydrocortisone or Solu-Cortef emergency kit with them. Further training provided by OHA on this subject can be found here.

TREATMENT:

A. Treat per Universal Patient Care protocol.
B. Obtain 12-lead ECG and CBG as part of assessment.
C. Acute Adrenal insufficiency (crisis) can occur in the following settings:
    a. During neonatal period (undiagnosed adrenal insufficiency)
    b. In patients with known, pre-existing adrenal insufficiency (eg, Addison's disease)
    c. In patients who are chronically steroid dependent (ie, taking steroids daily, long-term, for any number of medical conditions)
    d. Triggered by any acute stressor (eg, trauma or illness), as well as by abrupt cessation of steroid use (for any reason).
D. Signs/symptoms of adrenal crisis: Altered mental status, HA, dizziness, seizures, abd pain, nausea/vomiting, generalized weakness, hypotension, hypoglycemia, hyperkalemia.
E. If the patient is suspected of being in an acute adrenal crisis, **administer the patient's prescribed auto-injector** and transport.
F. Obtain vascular access.
G. Notify hospital you are transporting known/suspected adrenal crisis patient.
H. Acute adrenal crisis is an immediately ***life-threatening*** emergency, and must be treated aggressively

PEDIATRIC PATIENTS:

Same treatment protocol as adult patients. See above.