Section 700.12: Patients with adrenal insufficiency

Description of modification/clarification: This addenda is intended to create an awareness among field providers of persons in the community with adrenal insufficiency and prehospital treatment options.

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Approved by: Peter C. Springer, MD, FACEP

Effecting portion(s) of the document:

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Adrenal insufficiency – commonly referred to as Addison’s disease – is an endocrine disorder that results in insufficient production of cortisol (and aldosterone) by the adrenal glands (primary) or when adrenocorticotropic hormone production in the pituitary gland is insufficient (secondary). Adrenocorticotropic hormone is the hormone that stimulates cortisone production in the adrenal glands.

Adrenal insufficiency ordinarily requires no prehospital treatment. However, a stressful event (injury, illness, pregnancy, etc.) can precipitate or exacerbate adrenal insufficiency into an adrenal crisis.

If such a patient is encountered in the prehospital environment, field providers shall:

1. Determine if a history of adrenal insufficiency is known or suspected;
2. Assess for an event that may precipitate an adrenal crisis;
3. Assess for signs and symptoms of adrenal crisis to include: weakness; vomiting; diarrhea; sudden and severe lower back, abdominal, or leg pain; dehydration; abnormal vital signs; or altered mental status.

If any signs or symptoms are present, communicate the above information to the emergency department medical control physician and inquire whether methylprednisolone (Solu-Medrol), 2 milligrams per kilogram of body weight to a maximum dose of 125 milligrams, is desired.

Similar to other emergent conditions (anaphylaxis and opiate overdose), field providers need to be aware that persons, or care givers of persons, with adrenal insufficiency may self-treat with a corticosteroid during an adrenal crisis. Gather and document history obtained and treatment rendered consistent with existing documentation standards and convey any treatment to the receiving physician.