



15 July 2004

The Editor
The Lancet
correspondence@lancet.com

Dear Sir

Re: Adrenal Insufficiency Seminar, 31 May 2003, (Lancet 2003; 361: 1881 – 93)

Adrenal insufficiency

Sir—Congratulations to Wiebke Art and Bruno Alolio (May 31, p 1881)¹ for summarising the major issues with respect to diagnosis and management of adrenal insufficiency.

We wish to emphasise the challenges as regards long-term management of Addison's disease, especially with respect to crisis prevention. In this context, we note that Art and Alolio identified a rate of adrenal crisis needing hospital admission almost three times higher in women with primary autoimmune adrenalitis than in patients with secondary adrenal insufficiency.

In our opinion, all patients with Addison's disease should be issued with an emergency injection kit of 100 mg hydrocortisone and receive regular training in crisis prevention, including how to administer the injection. However, at present, many members of the UK Addison's Disease Self-Help Group receive limited or no follow-up instruction in how to deal with illness or injury after their initial diagnosis.

Some are issued an injection kit without clear guidance as to when they should use it and with no training for their partner in how to administer the injection.

In instances in which members of the Addison's Disease Self-Help Group have needed emergency treatment, we are aware that a delay of less than 2 h can see someone come close to death through a precipitate drop in blood pressure. If all patients with Addison's disease were issued with an injection kit, which could be administered at home while waiting for the ambulance, future near-death experiences could be prevented and the risk of permanent disability through respiratory failure or stroke induced by low blood pressure avoided.

Nowadays, individuals with Addison's disease are typically placed on replacement doses of hydrocortisone which are less than half the dose that was often administered in the 1970s. More recently-diagnosed patients do not,

therefore, have the same cushion of excess serum cortisol in their blood to surmount physical challenges such as strenuous exercise or infection. Some older patients on anachronistically high doses report an ability to shrug off injury and infections which would undoubtedly bring a patient on a lower replacement dose close to crisis. (See <http://www.adshg.org.uk> for case examples). Moves within the profession to encourage lower daily replacement doses, therefore, mean that endocrinologists should place renewed emphasis on education of patients with adrenal insufficiency and on crisis prevention.

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¹Art W, Alolio B. Adrenal insufficiency. *Lancet* 2003; 361: 1881–93.

Yours sincerely,

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*on behalf of the
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