PAW HEALTH NETWORK INC.

HYPOADRENOCORTICISM

ABOUT THE DISEASE

Adrenal glands secrete glucocorticoids (e.g., cortisol) for stress response and mineralocorticoids (e.g., aldosterone) for electrolyte regulation. Hypoadrenocorticism (Addison's disease) involves under-secretion of these hormones, impairing stress response and causing electrolyte imbalances.

Clinical Signs

Typically vague and waxing/waning: lethargy, vomiting, diarrhea, polyuria/polydipsia, weight loss.

Addisonian Crisis

Severe cases lead to life-threatening shock with weakness, collapse, seizures, hemorrhagic gastroenteritis, or death.

Types

- Primary: Adrenal gland dysfunction/autoimmune destruction.
- Secondary: Due to external causes (e.g., abrupt steroid withdrawal).

Classification

- Typical: Both hormone classes affected; significant electrolyte abnormalities.
  Atypical: Only glucocorticoids affected; normal electrolytes.

OBTAINING A DIAGNOSIS

Diagnosis in Addisonian Crisis

Electrolytes and baseline cortisol typically confirm.

Definitive Test (Non-Crisis)

ACTH stimulation test: Inject ACTH to stimulate adrenal hormone secretion; poor/no response indicates disease.

Interferences

Oral steroids (prednisone/prednisolone) may cause false results.

TREATMENT

Glucocorticoid Therapy

Low-dose oral prednisone/prednisolone; increase doses during stress to prevent crisis.

Mineralocorticoid Therapy

DOCP injection (Percorten-V/Zycortal) every 25 days for electrolyte balance.

Dosing

Individualized for steroids/DOCP based on patient response.

Monitoring

Check electrolytes 14 days post-injection; observe first weeks for depression, weakness, lethargy, vomiting, diarrhea.

TIPS FOR SUCCESS

- Ongoing Management – Consistent treatment and follow-up visits
- Stress Adjustments – Increase oral steroid dose during times of stress or strain
- Crisis Signs – weakness, collapse, unconsciousness; seek immediate evaluation