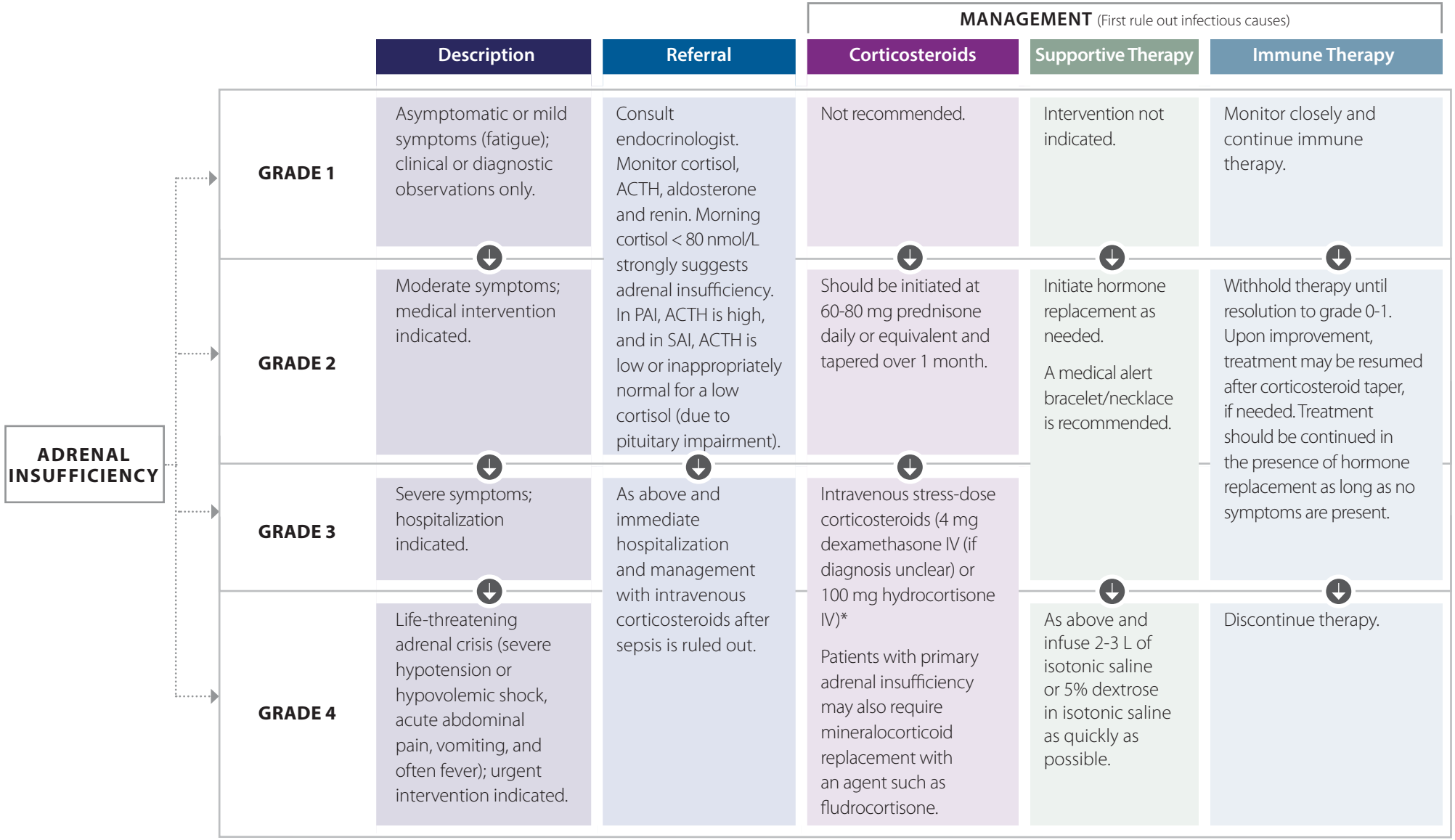
FIGURE 6

Management of Immune-Related Adrenal Insufficiency[2,4,10,13,14,17,23,24,25]

Background: Adrenal insufficiency can be classified as primary (PAI) if the adrenal glands are impaired or as secondary (SAI) if it is due to a failure of the hypothalamic-pituitary axis. Adrenal insufficiency occurs when the adrenal cortex does not produce enough cortisol (and in some cases aldosterone) and is usually characterized by hypotension, dehydration, and abnormal electrolytes, such as hyponatremia and hyperkalemia, that may mimic sepsis syndrome. Adrenal insufficiency is rare and has been reported in 0.7% of patients treated in randomized clinical trials. Adrenal insufficiency requires immediate intravenous corticosteroids after sepsis is ruled out, followed by an oral corticosteroid taper. Long-term steroid replacement is usually required. An endocrinologist should be involved and consulted as soon as adrenal insufficiency is suspected.



* Hydrocortisone is recommended if confirmed PAI. Continue dexamethasone 4 mg every 12 hours and hydrocortisone 200 mg per 24 hours (via continuous infusion or q6h bolus). Taper to maintenance doses over 2 weeks post-discharge.