Survey Questions

Asymptomatic adrenal suppression – Post-study survey
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Children with adrenal suppression (AS) may be asymptomatic, have non-specific signs and symptoms or be critically ill (adrenal crisis). Identifying and treating asymptomatic patients before they develop symptoms may reduce morbidity in this population. Official guidelines for screening for AS have yet to be developed. Consequently, screening practices – as demonstrated in the pre-study survey – are highly variable.

Before and after a two-year CPSP surveillance study of symptomatic AS, participants were surveyed to assess their screening practices for, and recognition of, AS. Results of the one-time pre-study survey were published in the CPSP 2010 Results. The post-study survey aimed to evaluate current practices of participants and assess the educational impact of the two-year study. The one-time post-study survey was sent to 2465 CPSP participants in April 2013. The response rate was 21% (n=521), compared to 32% in the pre-study survey. The percentage of physicians who reported routinely screening patients on GCs for AS increased from 10% in the pre-study survey to 21%. The number of physicians who reported having a screening policy in their office/centre also increased (from 6% to 11%). These increases may be attributable to awareness generated by the surveillance study. However, there was little change in the percentage of physicians who had diagnosed a child/youth with asymptomatic AS in the preceding year (from 12% to 10%).

First morning cortisol was the most frequently used test in both the pre- and post-study surveys (74% and 82% respectively). However, the low-dose ACTH stimulation test was used more often in the post-study survey – 21% in the pre-study survey compared to 43% in the post-study survey – suggesting an improved understanding of how to diagnose AS. One hundred and forty-four (28%) respondents reported that they had changed their approach to managing patients on GCs for AS over the past two years. Changes included closer surveillance of growth (n=117), routine screening (n=52), change in office policy (n=12), and change in hospital policy (n=7). Sixty-seven (13%) of the total respondents reported that their screening practice for AS changed because of the CPSP study – 65 changed their practice for inhaled corticosteroids (ICS) and 43 for systemic GCs.

Results of the previous two-year surveillance study suggested that children treated on the high but common dose of 500 mcg/day of fluticasone or greater should be screened for AS. In the post-study survey, 484 respondents answered a question regarding screening threshold for ICS; 223 (46%) do not screen children receiving only ICS, 153 (32%) screen for doses ≥500 mcg/day of fluticasone (or equivalent), 71 (15%) screen for doses >500 mcg/day and 37 (8%) reported “other”. A similar question in the one-time pre-study survey demonstrated that among the physicians who were screening patients taking ICS, >500 mcg/day was the most common threshold (n=47), followed by ≥500 mcg/day (n=32). The shift to the lower threshold over time (i.e., ≥500 mcg/day vs. >500 mcg/day) suggests improved awareness of the risks of AS.

Although screening for asymptomatic AS appears to have increased following the two-year study, the frequency of screening remains low compared with the frequency of children being treated with GCs. Development of a clinical practice guideline could increase awareness of asymptomatic AS among Canadian paediatricians and increase the identification of asymptomatic AS, before symptoms develop.

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