**Título:** PERIOPERATIVE MANAGEMENT OF A PATIENT WITH ADDISON'S DISEASE

**Autores:** Rita Ribas, Ana Filipa Monteiro, Alexandra Resende

**Instituições:** Centro Hospitalar Universitário Lisboa Norte

**Área Terapêutica/Tema:** Segurança dos Doentes (Patient Safety)

**Resumo**

Introduction:

Addison's disease is a endocrinopathy defined by atrophy or destruction of the adrenal gland, resulting in glucocorticoid and mineralocorticoid deficiency. Most commonly is caused by an autoimmune process.

The role of cortisol, the main hormone affected, is coping with stressful situations such as surgical stress. Signs and symptoms of this disease include weakness, weight loss, joint pain, postural hypotension, anorexia, hyponatremia, hyperkalemia and hypoglycemia.

Case Report:

A 82-year-old female weighing 40 Kg was scheduled for cemented hip arthroplasty due to a transcervical femur fracture. Medical history included: Addison´s disease diagnosed at age 12, managed by an endocrinologist and treated with chronic steroid therapy (oral dexamethasone 0.25 mg and hydrocortisone 20 mg), Hypertension and Hyperthyroidism.

Stress doses of intravenous 100 mg hydrocortisone were administered 2 hours before surgery, intra-operatively and in the postoperative period every 8 hours until gradually tapering the dose after 48 hours.

Combined spinal-epidural anesthesia used 8 mg of 0.5% levobupivacaine and 2,5 µg sufentanil in the subarachnoid space. Also an intravenous 500 mg tranexamic acid was given. Her intraoperative course was uneventful. During the 2-hour surgery, she maintained hemodynamic stability, normal fluid and electrolyte balance and lost approximately 200 mL of blood.

In the Postanesthetic Care Unit, an epidural test dose of 3 mL of 2% lidocaine was given and a Patient Controlled Epidural Analgesia (PCEA) with 0.1% ropivacaine at 4mL/h initiated for 48 hours.

Discussion:

The stress of surgery in the setting of a patient with Addison’s disease can precipitate an adrenal crisis. Perioperative management with glucocorticoid coverage is utterly important in the prevention of potentially life-threatening situations.

Even patients with treated adrenal insufficiency have significant morbidity and reduced life expectancy.

The anesthesiologist management is challenging and should include adequate fluid replacement, pain control and carefully weighted doses of steroids.

References:

Anaesthesia and adrenocortical disease. Anaesthesia, Critical Care & Pain, 2005; 5 (4): 122-126

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