61st St Andrew Day Symposium – Day 1

25 November 2021

Endocrine emergencies- Dr Rohana Wright

Q. Do we stop the alpha and beta blockers prior to adrenalectomy? Or is that done post op?
A. Stop immediately pre-op. Careful BP monitoring post-op before considering if ongoing therapy indicated.
Q. Do you believe that long-term steroids can lead to persisting Addisonism persisting for years after discontinuation?
A. Long term glucocorticoid therapy can lead to permanent adrenal suppression. Careful reduction of glucocorticoid dose and assessment of adrenal function is required. Reassessment can be undertaken after a further period. But there will be a subset of patients who have long term suppression and require lifelong hydrocortisone replacement.

Q. How soon will 2y insufficiency resolve after weaning steroids below prednisolone 5mg daily?
A. It is variable and I can't put a precise figure on that. It depends on dose/how long on treatment. If the patient is at risk of adrenal suppression based on dose/duration of therapy, you should consider adrenal suppression a possibility and assess HPA axis once steroids weaned. Some will be fine and have no ongoing requirement. Some will require hydrocortisone replacement with reassessment after a period, and a proportion of those will recover in time and be able to stop their hydrocortisone. Some will require long term replacement.

Q. For steroid replacement rules in Covid - are the proposed prednisolone dose increases in addition to the usual dose of dexamethasone we are likely to be giving?
A. The recommended Dexamethasone treatment dose in Covid-19 is equivalent to 240mg Hydrocortisone per day. So it will provide sufficient cover. But restarting their normal steroid must not be missed when they complete their Dexamethasone course. In the era of electronic prescribing hopefully many of us can ensure a stop date for the Dexamethasone and a restart date for usual steroid replacement is in place.
The recommended increases to usual glucocorticoid replacement really refer to non-hospitalised patients or those not unwell enough to be receiving Dexamethasone.

Q. How to manage tachycardia in patients with Asthma?
A. Calcium channel blockers such as Diltiazem would be an alternative but of course no direct impact on circulating thyroid hormones.

Q. Is there any guidance on how to step down steroids after it has been increased for an acute illness?
A. Short term increase in context of acute illness - reduce straight back down to usual replacement dose; no weaning required.

Q. If thyroid storm patient goes in cardiac arrest should we modify ALs ie amiodarone and adrenaline
A. No - proceed as per ALS protocol in that acute setting. Once ROSC achieved initiate emergency treatment as per presentation for thyroid storm.

The many faces of thrombosis in COVID-19 infection and after vaccination - Professor Beverley Hunt

Q. During CoVid I was shielded due to taking azathioprine and now dupixent. In an ironic way, do these drugs actually protect from immunothrobosis?

A. We don't really know.

Q. If see patients with covid who do not need admission, but look to be high risk for VTE prior to their covid - is it worth offering DOAC or LMWH in the short term?

A. If they do not have COVID pneumonia but only have mild COVID I would give the usual advice to stay mobile and hydrated. I would not offer anticoagulation.

Q. Are there anatomical reasons for a predilection to cerebral sinus thrombosis in VIIT? Is that also seen in HIT?

A. We do not know why the cerebral venous sinus is targeted in VITT. It is not commonly involved in HIT so it may be another factor within the vaccine that causes this predilection. It's a great Q!

Q. Beside Astrazenca, what other vaccines are reported to have issues with thrombosis

A. Adenoviral vaccines – the other is J&J

Q. Regarding VIT, given that it's the platelets receptors that predict the development of the disease as the case for HIT, would these patients would have developed HIT if given Heparin?

A. We know in HIT that polymorphisms in the platelet Fc receptor can predispose to HIT. This is a piece of research planned for the VITT patients. Ask this q again in a year!

Q. Why did the first reports regarding VITT come from Germany and not from the UK? We had vaccinated millions with AZ in the UK before the problem has transpired.

A. The reports come from across Europe simultaneously. The most advanced reports came from a lab in Germany where they work on HIT all the time, so could move forward quickly looking at pathogenesis

Q. VITT- can this be caused by MRNA vaccines

A. We don't think so

Q. How long after the covid still there is a risk of thrombosis?

A. With hospital-associated thrombosis we see the rates of VTE are increased above baseline for 90 days post discharge. We would expect the same for COVID

The neurology of TLoC and funny turns - Dr Richard Davenport

Q. How does one manage POTS? I struggle with some cases of POTS due to profound symptoms.

A. I do not think you are alone; the answer to this question is the subject of a lecture itself, along with other important questions such as "what is it", "how does one diagnose it" and "why is it so often

associated with functional symptoms"? I have no simple answers to any of these questions and my experience is that drugs are often unhelpful, a bit like this answer perhaps, sorry!

Q. Given the current pressure on OP services, how long is too long for these patients to wait for follow up?

A. Ideally such patients should be seen within 2 weeks. Like TIA clinics, the longer people wait, the less valuable the clinic becomes

Q. Do you give advice on medications to avoid? What do you stop?

A. I take this to mean what prescription drugs might cause TLoC? My experience is, a lot less frequently than unprescribed drugs! I rather rarely stop drugs in fact; tramadol is one, but the propensity of anti-depressants to trigger seizures is probably exaggerated. I think if you are thinking of stopping a drug, as yourself how much the patient may be benefitting (or otherwise) from that drug before you stop it.

Hyponatraemia - Professor Mirjam Christ-Crain

Q. What are the symptoms you would include in symptomatic hyponatremia when hypertonic saline indicated?

A. Usually, severe symptoms are considered if a patient is vomiting, cardiorespiratory distress, somnolence, has seizures, or coma. Moderately severe symptoms are considered in patients with nausea (without vomiting), confusion and headache. In patients with severe symptoms, 3% saline should be given asap, whereas in patients with moderately severe symptoms it depends and guidelines are not black and white (I would make it dependent on the patients status).

Q. After how long would you consider escalation of treatment if fluid restriction is not working - 24 hours or less?

A. 24 hours

Q. How much sodium chloride tablets are usually recommended?

A. the usual dose is 3g per day (which has also been used in the study of Krisanapan, 2020)

Q. Can you use 1.8% NaCl? Some trusts won't allow 3% on the AMU.

A. yes, but I do not have experience with it, we usually give 3% Saline and transfer patients for a short stay to our intermediate care unit.

Q. In treating hyponatraemia with 3% saline is this dependent only on symptoms or by sodium level.

A. It is mainly dependent on symptoms, e.g if a patient has a sodium levels of 125 (which is low, but not very low), but has symptoms, I would give 3% saline. The symptoms mainly depend on the dynamics of the fall in sodium levels, if the levels rapidly fall, this induces severe symptoms.

Q. What value to you give to using Furst formula to determine level of FR?

A. The Furst formula is used to estimate electrolyte free water clearance. If U/P is 0510, then commence fluid restriction of 500 mL/day. If U/P is < 05, then commence fluid restriction of 1000 mL/day. If U/P > 10, then there is no excretion of electrolyte-free water and fluid restriction is unlikely

to be beneficial. However, in my experience, it is much easier to just use urinary osmolality levels (>500 is very specific for NON-Response to FR, meaning you have to look for an alternative treatment)

Q. How quickly should we repeat Na level after giving bolous of 3% saline? And how quickly should we repeat the bolous?

A. Usually 100ml of 3% saline is recommended over 10 minutes or 150ml over 20 minutes, sodium levels should be checked after 20 minutes, while preparing a next infusion. It is suggested in guidelines to repeat the bolus until a target increase of 5mmol/L is reached, then stop the infusion and start a disease specific treatment.

Q. People with chronic low sodium on diuretics - is this a cause for concern and should attempts made to correct this?

A. yes, it has been shown that also patients with chronic hyponatremia who have no obvious symptoms do indeed have symptoms such as gait disturbance, attention deficits and osteopenia / osteoporosis. I would therefore recommend to correct their hyponatremia.

Q. if you have patient with Na level 102 and mild symptoms or aymptomatic would you still keep this patient at ward level

A Usually patients with that low sodium levels do have symptoms. If only mild symptoms, you can consider to treat them at ward level, however, please be aware that patients with that low sodium levels (especially if also malnutrition is present and liver disease) are at high risk for osmotic demyelinisation and this could be another reason to transfer such a patient to the ICU to be able to re-lower sodium levels quickly if the increase is too fast.

Q. What's your take on giving 0.9% Nacl 1litre as trial in SIAD ?

A. can be done, yes, but it is not always a clear diagnostic help. In case of diagnostic uncertainty, especially between SIAD and CSW, it may be a good option since there are no other parameters who do discriminate (except volemia).