E-Mail Consults

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Division of ENDOCRINOLOGY, DIABETES, METABOLISM & NUTRITION

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• Relevant Financial Relationship(s): None

• Off Label Usage: None

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• I chair the Endocrine Specialty Board (July 2014 – present)
• I am a member of the Endocrine Exam Committee (July 2013 – present)
• I am a member of the ABIM Council (July 2014 – present)
• As is true for any ABIM candidate who has taken the certification exam, I have signed a Pledge of Honesty in which I have agreed to keep the ABIM exam confidential
• No exam questions will be disclosed in my presentation

E-mail Consults

• Today we will browse my Outlook Inbox for e-mail frequent consult questions asked by clinicians in practice.
"E-mail Consults"

Let’s “Search” my E-mail Consult folder

Search for “Pheo” – N = 1,980 (29%)
Help please

44 y/o male
BP 140-150/80-95
Plasma met 0.14 nmol/l (0.049), normet **1.84 nmol/l (0.089)**
Urine mets 1400 ml, normet **1135 mcg/d (125-510)**, met 106 mcg/d (62-207)
(added normal ranges as not sure if there is a difference in regions)
CT – negative
MIBG – negative

He came to me with the above. Asymptomatic. While levels are high, I am not impressed overall. Do I keep searching?

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**Medications as of: Today (10/25/2016)**

- **Atorvastatin Calcium 10 MG Tablet**
- **Metformin HCl 500 MG Tablet**
- **Enalapril Maleate 20 MG Tablet**
- **Metoprolol Tartrate 25 MG Tablet**
- **Amlodipine Besylate 10 MG Tablet**
- **Hydrochlorothiazide 25 MG Tablet**
- **Testosterone Cypionate 200 MG/ML OIL**
- **Lugols 5 % Solution**
- **Zyrtec Allergy 10 MG TABS**
- **Protonix 40 MG TBE**
- **Skelaxin 800 MG TABS**
- **Flexeril 10 MG Tablet**

- Resume
- Continue
- Continue
- Continue
- Continue
- Continue
- Continue
- Start
- Taking
- Taking
- Taking
- Taking
E-mail Case #2

Hi Dr. Young,

I wondered if I could run a case by you. I have a patient with a 1.5 cm adrenal adenoma 3 HU, urine normetanephrines, total metanephrines and norepinephrines 2-3.5 times the ULN but he is on adderall, abilify, vyvanse and wellbutrin and is unable to be off these meds for 2 weeks for re-testing. I was planning to have him check a serum chromogranin A level and possibly an MIBG scan but would these meds also interfere with the scan results? Anything else you might suggest? Thanks so much in advance!

E-mail Case #3

Hi Dr. Young:

I am an endocrinologist in The University [redacted] I have a patient I would like to receive your insight.

A 55 yo apparently healthy patient was referred to me because of a 1.6 cm left adrenal incidentaloma found on a renal CT. The CT was originally ordered as a part of work up for kidney donation.

She is generally healthy and well, no chronic illness including hypertension. Essentially she has no symptoms or signs of Cushing’s or catecholamine excess. And her BP was 123/74 in a sitting position with HR of 80/min at the time of visit. She was not on any medications including acetaminophen.
**E-mail Case #3**

**From:** [Redacted]  
**To:** Young, Willem F., Jr., M.D.  
**Subject:** Question regarding evaluation of pheochromocytoma

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**NORMETANEPHRINE PLASMA 0.28 nmol/L [0.00-0.89]**  
**METANEPHRINE PLASMA 0.76 H nmol/L [0.00-0.49]**

A 24 hour metanephrines were ordered and results are as below:

**METANEPHRINE UT 273 H ug/d 39-143**  
**NORMETANEPHRINE UT 136 ug/d 109-393**  
**CREATININE UT 681 mg/d [500-1400]**  
**VOLUME ml 1098 mL**

To me, she doesn’t have pheochromocytoma as total catecholamines and total metanephrines were normal and epinephrine was low normal even at baseline and further suppressed by a 0.3 mg clonidine mainly because of reduction of NE and NM.

But there is a lingering concern that a mildly elevated MN may be a biochemical evidence of early stage of adrenal pheochromocytoma.

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**Hi Dr. Young:**

I am an endocrinologist in The University [Redacted] I have a patient I would like to receive your insight.

By the way, an MRI-adrenal was ordered by a nephrologist prior to her visit with me and a radiologist read it as follows:

**FINDINGS:**

A 1.6 cm T1-weighted hyperintense, T2-weighted hyperintense, enhancing lesion within the left adrenal gland medial limb. This demonstrates increased signal on the out-of-phase compared to the in-phase sequence which is incompatible with a lipid rich adenoma.
Search for “Aldo” – N = 2,069 (31%)

E-mail Case #4

From: [Name]
To: Young, William F. Jr., M.D.
Sent: Tue 8/18/2015 9:15

Bill, hope your end of summer is going well. We saw a patient on Friday with what I consider to be a high likelihood for primary aldosteronism. 5 drug HTN, huge potassium requirements, Aldo 30 / renin <0.06 on screening; aldo of 16 after 2 L saline while he was hospitalized recently, L adrenal thickening with small nodule. The kicker is that he has chronic renal failure with an eGFR of 35 cc/h. We are planning AVS but I wanted to make sure that his biochemistries were not confounded by CRI. I asked him to do a 24 hr urine with some increased sodium intake to get confirmation with the w/u I am most used to. A quick pubmed didn’t give me the answer I was looking for, but I suspect you can. This must come up all the time.
**E-mail Case #5**

From: [Redacted]
To: [Redacted], William F., Jr., M.D.
Cc: [Redacted]
Subject: [Redacted] from baylor College of Medicine: Hyperaldosterone Evaluation Question

Dear Dr. Young,

I am an Endocrine fellow at [Redacted] College of Medicine. I have a patient I would like your advice on. A particularly difficult to control hypertensive patient with bilateral adrenal nodules is being evaluated for primary hyperaldosteronism. I would like to know if AVS can be performed while the patient is on eplerenone. The guidelines state that patient should be off the aldosterone antagonists for 6 weeks. In this particular patient, the HTN is uncontrolled despite multiple (6) medications which include eplerenone.

Your opinion is very valuable. Looking forward to your response.

Sincerely,

[Redacted]

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**E-mail Case #6**

From: [Redacted]
To: [Redacted], William F., Jr., M.D.
Cc: [Redacted]
Subject: A case of primary aldosteronism.

Hello Dr. Young,

I have a 46 year of male patient with a hx of primary aldosteronism -aldosterone-producing adenoma (APA), secondary HTN diagnosed in 2002. He refused surgery and prefers medical management. I saw him for the first time last September and changed his regimen from Spironolactone to Eplerenone given intolerance to Spironolactone.

He BP is well controlled on this medication regimen:

Eplerenone 300 mg once a day.
Potassium 30 MEQ twice a day.
Amlodipine 5 mg once a day.

His current labs are:
E-mail Case #6

Component | Latest Ref | BUN 8 - 20 mg/dL | Component | Latest Ref | BUN 8 - 20 mg/dL
----- | ---- | ---- | ----- | ---- | ----
NA | 135 - 145 mEq/L | CA | 8.6 - 10.3 mg/dL | NA | 135 - 145 mEq/L
K | 3.6 - 5.0 mEq/L | ANION GAP4 SERPL | 2.0 - 13.0 mEq/L | K | 3.6 - 5.0 mEq/L
CL | 101 - 114 mEq/L | RENIN A D | 0.25 - 5.820.16 (L) | CL | 101 - 114 mEq/L
CO2 | 21 - 31 mEq/L | GLUC | 70 - 99 mg/dL | CO2 | 21 - 31 mEq/L
GLUC | 70 - 99 mg/dL | CREAT | 0.6 - 1.3 mg/dL | GLUC | 70 - 99 mg/dL
CREAT | 0.6 - 1.3 mg/dL | CREAT | 0.6 - 1.3 mg/dL

E-mail Case #6

From: [Redacted]
To: Young, William F., Jr., M.D.
CC: 
Subject: A case of primary aldosteronism

Questions:

1. Since he continues to require 60 MEQ of K/day, would an increase in Eplerenone dose to 400 mg/day be beneficial when compared to 300 mg/day?

2. Should I consider adding a potassium sparing diuretic at this time in order to decrease his K requirement?

3. Does monitoring PRA have a role in monitoring these patient's or determining treatment efficacy other than monitoring blood pressure, serum K and serum creatinine?

Thank you.

Rachel.
E-mail Case #7

From: [Redacted]  
Sent: Fri 7/24/2015 4:37 PM  
To: [Redacted], William F., Jr., M.D.  
Cc:  
Subject: question about patient undergoing adrenalectomy for hyperaldosteronism

Hello Dr. Young,
How are you? This is [Redacted]. I am an endocrinologist on faculty at [Redacted].

I have a patient with hyperaldosteronism coming in for adrenalectomy. They are on three anti-hypertensive medications - clonidine 0.1 mg, betablocker, and norvasc 10mg. Post-operatively we will monitor the patient without BP meds and follow BP Q 4hours. We will start beta blocker as needed. We will also follow potassium levels closely afterwards.

We were not planning to stop the clonidine prior to the procedure, would you agree with this protocol?

Also, in the past we have discussed the criteria for positive adrenal venous sampling. Would you have the reference for this criteria - so that I can share it with the fellows here?

Thank you.

Search for “biopsy” – N = 394 (6%)
Dr. Young,

I am evaluating a patient with a heterogenous, hypervascular, hyperintense T2 3cm adrenal mass that was read as “suspicous for pheo”. She also, however, has a h/o breast cancer 2008, and has a stable hepatic mass (and known hep C) and stable cystic pancreatic lesion. Normal 24 hr urine metas and catehols. I am going to alpha and beta block her regardless. You have done your job indoctrinating me on imaging phenotype.

My question is this: in a circumstance where we could be dealing with pheo or metastatic malignancy is it better to just take it out, versus biopsy. Alpha and beta blockade on board either way. My rare experience with biopsy has not been good. Whereas my lap adrenalectomy patients have sailed through surgery wonderfully.