

Survey

Patients with asymptomatic adrenal suppression

Glucocorticoid (GC) therapy is used in a variety of paediatric conditions. Adrenal suppression (AS), which results in an inability to produce adequate amounts of cortisol, is a clearly proven but under-recognized complication of GCs and can be life-threatening. The clinical presentation of AS can vary from asymptomatic to critical illness.



This survey will evaluate how frequently CPSP participants see paediatric patients treated with GCs and cases of asymptomatic AS due to GC treatment, and AS screening practices.

Your contribution is greatly appreciated.

1. **Over the past month**, have you seen any children/youth under the age of 18 years currently being treated with *any form* of GCs (e.g., inhaled, oral, intravenous, intramuscular)?
Yes ___ No ___ If yes, how many? <5 ___ 5-10 ___ 11-20 ___ 21-50 ___ 51-100 ___ >100 ___
2. **Over the past year**, have you diagnosed any children/youth with asymptomatic AS?
Yes ___ No ___ **If no, proceed to question 4.**
If yes, how was AS diagnosed? (Check all that apply.)
Morning cortisol ___ Random cortisol ___ 24-hour urinary cortisol ___
Standard-dose ACTH stimulation test ___ Low-dose ACTH stimulation test ___
Other (specify) _____
3. For cases of asymptomatic AS, what condition(s) was/were the GCs being used for? (Check all that apply.)
Asthma ___ Inflammatory bowel disease ___ Malignancy ___ Nephrotic syndrome ___
Rheumatologic disease ___ Other (specify) _____
4. Do you routinely screen patients on GCs for AS? Yes ___ No ___
5. Do you have a minimum GC dose which would prompt you to screen for AS? Yes ___ No ___
If yes, specify generic name (e.g., prednisone, fluticasone), type (e.g., oral, inhaled, intravenous), and dosage:

6. Does your centre/office have a screening policy for AS?
Yes ___ No ___ Unsure ___
7. Which of the following best describes your practice? (Check all that apply.)

<input type="checkbox"/> adolescent medicine	<input type="checkbox"/> emergency	<input type="checkbox"/> nephrology
<input type="checkbox"/> allergy/immunology	<input type="checkbox"/> endocrinology/metabolism	<input type="checkbox"/> neurology
<input type="checkbox"/> cardiology	<input type="checkbox"/> gastroenterology	<input type="checkbox"/> oncology
<input type="checkbox"/> consultation	<input type="checkbox"/> haematology	<input type="checkbox"/> primary care
<input type="checkbox"/> critical care	<input type="checkbox"/> infectious disease	<input type="checkbox"/> respirology
<input type="checkbox"/> dermatology	<input type="checkbox"/> medical genetics	<input type="checkbox"/> rheumatology
<input type="checkbox"/> development/behaviour	<input type="checkbox"/> neonatology/perinatology	

 Other (specify): _____

Please return this survey with your monthly reporting form.

Thank you for your participation.

03/2010