

Secondary hyperaldosteronism

Secondary hyperaldosteronism is a condition of increased adrenal production of aldosterone in a non-pituitary, extra-adrenal response to stimuli. It is usually caused by decreased renal blood flow which can be produced by other primary conditions.

Code

ICD-10 CODE	DESCRIPTION
E26.1	Secondary hyperaldosteronism

Identifying causes of secondary hyperaldosteronism

Primary conditions that can cause hyperaldosteronism are:

- Obstructive renal artery disease
- Renal vasoconstriction (as happens in accelerated hypertension)
- Edematous disorders such as:
 - Heart failure
 - Cirrhosis with ascites
 - Nephrotic syndrome

Identifying conditions causing secondary hyperaldosteronism ⁱ		
Clinical Finding	Renovascular or Accelerated HTN	Edematous Disorders ^{**}
Blood pressure	↑↑↑	N or ↑
Edema	Rare	Present
Serum sodium	N or ↓	N or ↓
Serum potassium	↓	N or ↓
Plasma renin activity*	↑↑	↑
Aldosterone	↑↑	↑
*When corrected for age; elderly patients have lower mean plasma renin activity.		
**Examples of edematous disorders are heart failure, nephrotic syndrome, and cirrhosis.		
↑↑↑=very greatly increased; ↑↑=greatly increased; ↑=increased; ↓↓=greatly decreased; ↓=decreased; N=normal		

Documentation requirements

To ensure proper diagnosis capture the following elements should be included:

- Document any clinical findings that led to the diagnosis such as: BP, edema, any abnormal labs, etc.
- Identify the primary condition accountable for the aldosteronism (e.g., HF, cirrhosis) and its status.
- Be sure to link the secondary condition back to the primary diagnosis using linking language such as due to, secondary to, caused by or associated with.
- Include an assessment and plan for both the primary and secondary conditions.

Documentation Best Practices handouts are designed to help WellSense providers improve and record the quality of care delivered to WellSense members across all patient populations.

Documentation examples

CHF with secondary hyperaldosteronism

- HPI:** Patient is a 72-year-old male here for a follow-up of his NYHA class III heart failure. He states that he has had shortness of breath with walking and other exertion the past few weeks, but no symptoms while at rest. He has also noticed more leg swelling than he normally has and would like to discuss this.
- PE:** Vitals: WNL; ROS: Negative; PE: WNL except for S3 gallop on heart exam and 3+ pitting edema.
- A:** **I50.22 Chronic systolic congestive heart failure**
E26.1 Secondary hyperaldosteronism due to heart failure
- P:** Continue metoprolol as prescribed. Refills sent in to patient's pharmacy. Furosemide increased to 40 mg daily. Referral back to cardiology to discuss possibly starting spironolactone. Appointment to be scheduled at patient's convenience.

Cirrhosis with secondary hyperaldosteronism

- HPI:** Patient is a 67-year-old male that presents for follow up of cirrhosis of the liver. He has noticed an increase in abdominal girth over the past month.
- PE:** Vitals: Normal; PE: WNL except for positive fluid wave test; ROS: Negative
- A:** **K74.60 Unspecified cirrhosis of liver**
E26.1 Secondary hyperaldosteronism
- P:** Patient has developed secondary hyperaldosteronism due to cirrhosis, causing ascites in the abdomen. Continue current treatment for liver disease. Add spironolactone 25 mg once daily. Refer to GI for further recommendations.

ⁱSecondary Aldosteronism - Endocrine and Metabolic Disorders - Merck Manuals Professional Edition