INTRODUCTION

Congenital adrenal hyperplasia (CAH) and long-term glucocorticoid treatment may be associated with an increased risk of developing glucose homeostasis, hyperlipidaemia, hypertension, cardiovascular disease (CV), and obesity.

AIM

• To study the current practice amongst expert centres for assessing cardiometabolic outcomes (type 2 diabetes, hyperlipidaemia, hypertension, cardiovascular disease, obesity, osteoporosis) in adult patients with 21-hydroxylase deficiency CAH.

• To assess the prevalence of cardiometabolic morbidity among centres

METHOD

• Data were collected using a structured questionnaire sent to 46 centres managing adults with CAH within three overlapping networks: I-CAH Registry, CAHES Consortium UK and Endo-ERN.

• Further information asked to centres included current therapy and surveillance practice of adults with CAH with emphasis on cardiometabolic conditions.

RESULTS

The Practice Of Monitoring Cardiometabolic Morbidity

• 31 centres from 15 countries replied to the Survey: 97% screen patients for comorbidities.

• There is a need for greater standardisation of the screening for these morbidities.

• There is a need to optimize therapy through routine collection of standardised data.

CONCLUSIONS

• Cardiometabolic morbidities are not uncommon in adults with CAH.

• There is a need for further standardisation of the screening for these morbidities.

• There is a need to optimize therapy through routine collection of standardised data.

REFERENCES


The Extent Of Cardiometabolic Morbidity

• Data on 255 adults (median age of 32 years, range 19-94) were reported from 13 centres.

• Of 255, 78 (31%) were receiving drug therapy for a cardiometabolic morbidity and, of these, 13 (17%) were treated for 2 or more comorbidities.

<table>
<thead>
<tr>
<th>Comorbidity</th>
<th>N (%) of pt affected</th>
<th>N (%) of pt affected on therapy</th>
<th>Median age (yr) at start therapy (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity/overweight</td>
<td>93 (36)</td>
<td>3 (3%)</td>
<td>27 (17, 55)</td>
</tr>
<tr>
<td>Osteoporosis/osteopenia</td>
<td>58 (23)</td>
<td>43 (74%)</td>
<td>34 (18, 63)</td>
</tr>
<tr>
<td>Hyperlipidaemia</td>
<td>50 (20%)</td>
<td>17 (34%)</td>
<td>55 (19, 79)</td>
</tr>
<tr>
<td>Type2DM/Impaired glucohomeostasis</td>
<td>20 (8%)</td>
<td>18 (90%)</td>
<td>27 (14, 78)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>18 (7%)</td>
<td>10 (50%)</td>
<td>55 (39, 71)</td>
</tr>
<tr>
<td>CV disease</td>
<td>10 (4%)</td>
<td>8 (80%)</td>
<td>65 (55, 72)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Abnormal glucose homeostasis</th>
<th>Hyperlipidaemia</th>
<th>Hypertension</th>
<th>Cardiometabolic disease</th>
<th>Obesity</th>
<th>Osteoporosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metformin (n=14)</td>
<td>Alovostatin (n=6)</td>
<td>Alovostatin (n=3)</td>
<td>ASA (n=4)</td>
<td>Orlistat (n=1)</td>
<td>Vitamin D (n=7)</td>
</tr>
<tr>
<td>Insulin (n=3)</td>
<td>Simvastatin (n=5)</td>
<td>Enalapril (n=1)</td>
<td>Metformin (n=1)</td>
<td>Calcium (n=5)</td>
<td>Pravastatin (n=6)</td>
</tr>
<tr>
<td>Fosinopril (n=2)</td>
<td>Ramipril (n=2)</td>
<td>Clonipride (n=1)</td>
<td>Lisoprin (n=1)</td>
<td>Rosiprins (n=1)</td>
<td>Losartan (n=1)</td>
</tr>
<tr>
<td>Rosinestatin/Estrenil (n=1)</td>
<td>Nitidipine (n=1)</td>
<td></td>
<td></td>
<td></td>
<td>Fosumide (n=1)</td>
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<td>Rivarsobrin (n=1)</td>
</tr>
</tbody>
</table>

- Fasting blood glucose
- BMI (%: overweight (%)
- Hba1c (%: normal (%) fasting glucose
- Dma scan (%)
- Fasting kala (%)
- Lirandie US (%)

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