Supplementary Table 2 Management of adrenal crisis (adapted from Arlt 2016)

Initial management of an Adrenal Crisis

- **Adrenal insufficiency should be ruled out in any acutely ill patient with signs or symptoms potentially suggestive of acute adrenal insufficiency**
- **Assess blood pressure and fluid balance status;** if clinically feasible, measure blood pressure from supine to standing to check for postural drop
- **Take drug history**
    - **history of steroid use-any route of delivery**
    - **antiretrovirals**
    - **itraconazole or other CYP3A4 inhibitors**

Bloods:

- Sodium, potassium, urea, creatinine
- Full blood count
- TSH, fT_4 (hyperthyroidism can trigger adrenal crisis; acute adrenal insufficiency can increase TSH due to loss of inhibitory control of TRH release, do not replace with thyroxine if TSH ≤ 10 mU/L)
- **Paired serum cortisol and plasma ACTH**

Confirmatory tests

- If the patient is haemodynamically stable, consider performing a **short Synacthen test** (serum cortisol at baseline and 30 min after i.v. injection of 250 micrograms $ACTH_{1–24}$); however, if the patient is severely ill, confirmation of diagnosis can be safely left until after clinical recovery following implementation of emergency dose hydrocortisone treatment
- Serum/plasma aldosterone and plasma renin (aldosterone will be low and renin high in primary adrenal insufficiency; observe special sample collection and transport conditions; can be left to confirmation of diagnosis after clinical recovery)