

# Secondary hyperaldosteronism



# Secondary aldosteronism or secondary hyperaldosteronism

---

**Any condition reducing renal perfusion can lead to secondary hyperaldosteronism.**

Decreased blood flow to the kidneys results from:

- impaired cardiac function in heart failure

**Or**

- portal hypertension in cirrhosis

In both cases, this triggers the renin-angiotensin-aldosterone system which results in a state of **increased aldosterone** caused by a condition **outside** the adrenal glands.

## When is it appropriate to diagnose secondary hyperaldosteronism?

---

**Secondary hyperaldosteronism** can be diagnosed if **one** of the following is present:

- Class III or IV heart failure with or without edema
- Class I or II heart failure with edema or diuretic use/prescription
- Cirrhosis with ascites, edema or diuretic use/prescription
- Unexplained hypokalemia in the presence of cirrhosis or heart failure while not on a diuretic

# Heart failure type

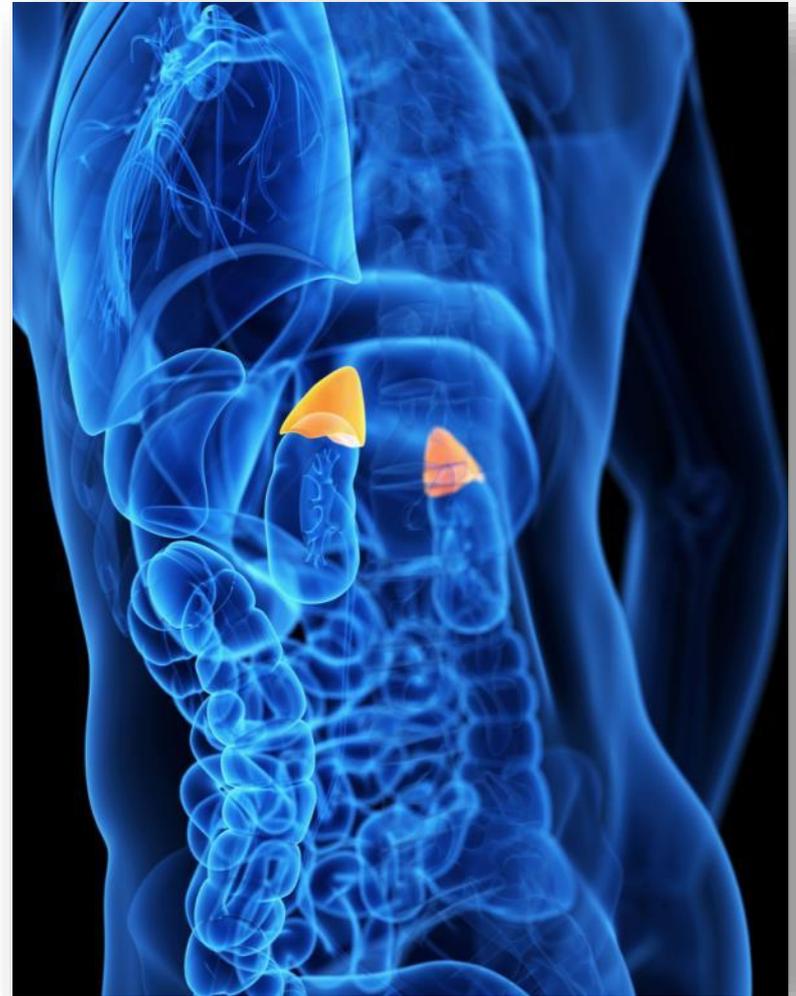
| New York Heart Association Functional Class |  |
|---|--|
| Class                                       |  |
| I.  | No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).                     |
| II.   | Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).      |
| III.  | Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.                            |
| IV.   | Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases |

# Potential treatment option

Patients with secondary hyperaldosteronism may benefit from loop diuretics.

Certain patients may benefit from aldosterone receptor blockade by spironolactone or eplerenone.

Close monitoring for hyperkalemia is necessary.



## Documentation tips

Document the **clinical findings** which lead to the diagnosis of the **primary condition** responsible for the aldosteronism and its status, the diagnosis of **secondary aldosteronism /hyperaldosteronism**, and a **plan of care**.

Secondary aldosteronism and secondary hyperaldosteronism have the **same code** in ICD-10-CM (**E26.1**) so either may be documented.

# Documentation tips

As with most secondary diagnoses due to an underlying primary condition, the causal condition should be identified and documented, **if known**.

For example:

- Secondary aldosteronism (**E26.1**) due to heart failure (**I50.9**)
- Alcoholic cirrhosis of liver with ascites (**K70.31**) and secondary hyperaldosteronism (**E26.1**)
- Aldosteronism, secondary (**E26.1**) due to severe renal artery stenosis (**I70.1**)

# Scenario one

---

- **HPI:** Patient with Class III HF presents for f/u.
- **PE:** WD/WN male SOB with walking, but not at rest. Chest: clear; Heart: RRR with gallop; Ext: 3+ pitting edema.

---

## Assessment:

- **HF** (I50.9); Class III by sx/s/exam
- **Secondary hyperaldosteronism** (E26.1); c to Class III HF as above
- **Plan:** Continue furosemide and spironolact; hyperkalemia and worsening signs and sym



**Appropriate**

# References

---

- <https://www.uptodate.com/contents/use-of-mineralocorticoid-receptor-antagonists-in-heart-failure-with-reduced-ejection-fraction>
- [http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Clinical-Assess-of-Heart-Failure\\_UCM\\_306328\\_Article.jsp#.WMmGMofruUm](http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Clinical-Assess-of-Heart-Failure_UCM_306328_Article.jsp#.WMmGMofruUm)

Information in this course is to be used for easy reference; however, the ICD-10-CM code book and the Official Guidelines for Coding and Reporting are the authoritative references for accurate and complete coding. The information presented herein is for general informational purposes only. Neither Optum nor its affiliates warrant or represent that the information contained herein is complete, accurate or free from defects. Specific documentation is reflective of the “thought process” of the provider when treating patients. All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment, and coded to the highest level of specificity. Enhanced precision and accuracy in the codes selected is the ultimate goal.

For more information on the CMS-HCC Risk Adjustment model for 2017 see: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents-Items/2017Announcement.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>

---

This presentation was produced by Clinical Documentation and Quality Improvement (CDQI) please do not use/alter without approval

---