Mild Adrenocortical Deficiency (a.k.a. Adrenal Fatigue): A Real Diagnosis?

As a clinician in practice for over fourteen years, I find it unfortunate that mild adrenocortical deficiency (MAD) has not been endorsed by clinicians other than those within the complementary and alternative medicine (CAM) world. It is not implausible that when the physiological mechanisms that restore homeostasis following stress of any kind have been strained for many years, or have been repeatedly strained as a result of many acutely stressful events, the ability to produce adequate amounts of cortisol might be compromised. As a result, the individual begins to manifest signs and symptoms reflective of this inability to produce sufficient amounts of cortisol.

The academic literature on MAD began with the work of Dr. John Tintera, who documented in 1955 the clinical manifestations of MAD and how best it can be managed.[1] Dr. William Jefferies expanded on the work of Tintera, and reported in 1981 in his seminal book, *Safe Uses of Cortisol* (now in its 3rd edition), the benefits of low-dose (or physiological doses) of cortisol as a means to correct for MAD and other medical conditions in which the production of cortisol is compromised.[2]

The use of MAD diagnostically is viewed by many mainstream clinicians as a diagnosis that has little scientific merit. For example, The Hormone Foundation and Endocrine Society published a fact sheet in 2010 in which they emphatically deny the existence of MAD and assert that there is no credible scientific literature to support this diagnosis.[3] They also note their concern that if MAD is used diagnostically than the "real" cause of symptoms might not be found. Even the prestigious Mayo Clinic has dismissed this diagnosis in one of their postings, "Is there such a thing as adrenal fatigue?" in which they state:

"It's frustrating to have persistent symptoms your doctor can't readily explain. But accepting a medically unrecognized diagnosis from an unqualified practitioner could be worse. Unproven remedies for so-called adrenal fatigue may leave you feeling sicker, while the real cause, such as depression or fibromyalgia, continues to take its toll."[4]

This dismissal makes little sense when one considers psychiatric diagnoses. Are the Mayo Clinic and The Hormone Foundation and Endocrine Society noting their concerns about psychiatric diagnoses as well? Not one psychiatric diagnosis has any laboratory test that helps in identifying its existence. I would argue, however, that the use of MAD is more legitimate than using a psychiatric diagnosis since there are times when laboratory tests can help in its identification. For example, a twenty-four hour urine collection assessing free cortisol can sometimes capture the deficiency. Salivary testing, while controversial, might also pick up an abnormal circadian rhythm of cortisol secretion throughout a twenty-four hour period. Ultimately, the best way to confirm the presence of MAD is to treat the patient and see if the treatment results in an improvement. If so, then the diagnosis of MAD was correct and justifiable. If the treatment does not yield a positive change in symptoms reflective of MAD than any good clinician should either institute more effective treatment, or perhaps consider an alternative diagnosis (i.e., working hypothesis) that better explains the patient's medical problems.

All psychiatric diagnoses are predicated on an interview of the patient. Then, the rendering of a diagnosis is based on the clinician's opinion of what best "label" (i.e., psychiatric diagnosis) accurately reflects the patient's mental state. The entire system of psychiatric diagnosis is beyond fallible; in fact, it is outright ridiculous when one considers how normal (yet maladaptive behaviours) are being pathologized and made into legitimate psychiatric diagnoses. In the coming year or so, we will likely see a new crop of psychiatric diagnoses, such as "Binge-Eating Disorder," "Sluggish Cognitive Tempo," and "Temper Dysregulation Disorder." So, if you tend to overeat at night (binge eating disorder) due

to stress imposed by your misbehaving child (temper dysregulation disorder), and you live with a wife that is more relaxed about parenting and subject to overly mellow periods (sluggish cognitive tempo disorder), than it is entirely possible that you and your loved ones have a psychiatric diagnosis. The good news is that there will certainly be prescription drugs offered to assuage the devastation caused by these "legitimate" diagnoses.

The point being, it is entirely appropriate to use a diagnosis of MAD if it best explains a patient's medical presentation. CAM providers should not be vilified for using MAD as a diagnosis considering the precarious nature of many "acceptable" psychiatric diagnoses in use today. Given how stressed many people are, and how many turn to their clinicians only to be told that nothing is wrong with them, the use of MAD might offer these patients not only legitimacy to their suffering, but also effective treatment based on sound logic and basic physiology.

For this issue, I have written a comprehensive review article on MAD and its relationship to several difficult-to-treat medical conditions. My hope is that this article will advance the body of literature in support of MAD, and also shed light on the most appropriate treatment strategies for overcoming the deficit in cortisol production.

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References

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