# Overview

## Useful For
Investigation of primary aldosteronism (e.g., adrenal adenoma/carcinoma and adrenal cortical hyperplasia) and secondary aldosteronism (renovascular disease, salt depletion, potassium loading, cardiac failure with ascites, pregnancy, Bartter syndrome)

## Testing Algorithm
See Steroid Pathways in Special Instructions.

## Special Instructions
- Renin-Aldosterone Studies
- Steroid Pathways

## Method Name
Liquid Chromatography-Tandem Mass Spectrometry (LC-MS/MS)

## NY State Available
Yes

# Specimen

## Specimen Type
Serum

## Specimen Required
Collection Container/Tube:
- **Preferred:** Red top
- **Acceptable:** Serum gel

**Submission Container/Tube:** Plastic vial

**Specimen Volume:** 1.2 mL

**Collection Instructions:** 8 a.m. collection time (after the patient is active for 2 hours) is recommended; preferably no later than 10 a.m.

**Additional Information:** See Renin-Aldosterone Studies in Special Instructions for more detailed instructions.

## Forms
If not ordering electronically, complete, print, and send 1 of the following forms with the specimen:

- General Request (T239)
- Cardiovascular Test Request (T724)

## Specimen Minimum Volume
Test Definition: ALDS
Aldosterone, S

1.2 mL

Reject Due To

<table>
<thead>
<tr>
<th>Condition</th>
<th>Status</th>
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<tr>
<td>Gross lipemia</td>
<td>OK</td>
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<tr>
<td>Gross icterus</td>
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Specimen Stability Information

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Temperature</th>
<th>Time</th>
<th>Special Container</th>
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<tbody>
<tr>
<td>Serum</td>
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</tr>
<tr>
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<td>Frozen</td>
<td>30 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ambient</td>
<td>4 days</td>
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Clinical and Interpretive

Clinical Information

Aldosterone stimulates sodium transport across cell membranes, particularly in the distal renal tubule where sodium is exchanged for hydrogen and potassium. Secondarily, aldosterone is important in the maintenance of blood pressure and blood volume.

Aldosterone is the major mineralocorticoid and is produced by the adrenal cortex.

The renin-angiotensin system is the primary regulator of the synthesis and secretion of aldosterone. Likewise, increased concentrations of potassium in the plasma may directly stimulate adrenal production of the hormone. Under physiologic conditions, pituitary adrenocorticotropic hormone is not a major factor in regulating aldosterone secretion.

See Steroid Pathways in Special Instructions.

Reference Values

0-30 days: 17-154 ng/dL*

31 days-11 months: 6.5-86 ng/dL*

1-10 years:

< or =40 ng/dL (supine)*

< or =124 ng/dL (upright)*

> or =11 years: < or =21 ng/dL (a.m. peripheral vein specimen)

For International System of Units (SI) conversion for Reference Values, see https://www.mayocliniclabs.com/order-tests/si-unit-conversion.html

Interpretation

A high ratio of serum aldosterone (SA) in ng/dL to plasma renin activity (PRA) in ng/mL per hour, is a positive screening test result, a finding that warrants further testing. An SA/PRA ratio greater than or equal to 20 is only interpretable with an SA greater than or equal to 15 ng/dL and indicates probable primary aldosteronism.

Renal disease, such as unilateral renal artery stenosis, results in elevated renin and aldosterone levels. Renal venous catheterization may be helpful. A positive test is a renal venous renin ratio (affected/normal) greater than 1.5.

See Renin-Aldosterone Studies and Steroid Pathways in Special Instructions.

Note: Advice on stimulation or suppression tests is available from Mayo Clinic's Division of Endocrinology and may be obtained by calling 800-533-1710.

Cautions

The plasma renin activity (PRA) cannot be interpreted if the patient is being treated with spironolactone (Aldactone). Spironolactone should be discontinued for 4 to 6 weeks before testing.

Late p.m. levels can be up to 30% lower than early a.m. levels. Supine values are on average 50% lower than upright collections. Sodium deplete subjects have significantly elevated serum aldosterone (SA) levels, potentially exceeding the upper limit of the salt replete upright reference range by several fold. To account for these variables, at least in part, it is recommended that PRA is measured concomitantly. In situations of physiological variability, PRA should be altered in the same direction as aldosterone. See Renin-Aldosterone Studies in Special Instructions.

Angiotensin converting enzyme (ACE) inhibitors have the potential to falsely elevate PRA. Therefore, in a patient treated with an ACE inhibitor, the findings of a detectable PRA level or a low SA/PRA ratio do not exclude the diagnosis of primary aldosteronism. In addition, a strong predictor for primary aldosteronism is a PRA level undetectably low in a patient taking an ACE inhibitor.

Clinical Reference


Performance

Method Description

Aldosterone-d6 is added to serum and plasma samples as an internal standard. Aldosterone and aldosterone-d6 are extracted from the specimens using a Strata X cartridge. The eluate is dried down under nitrogen, reconstituted with 70/30 methanol/H2O containing estriol and analyzed by liquid chromatography-tandem mass spectrometry using multiple reaction monitoring in the negative mode. (Fredline VF, Taylor PJ, Dodds HM, Johnson AG: A reference...

PDF Report
No

Day(s) and Time(s) Test Performed
Monday through Friday; 4 p.m.

Analytic Time
2 days

Maximum Laboratory Time
5 days

Specimen Retention Time
14 days

Performing Laboratory Location
Rochester

Fees and Codes

Fees
- Authorized users can sign in to Test Prices for detailed fee information.
- Clients without access to Test Prices can contact Customer Service 24 hours a day, seven days a week.
- Prospective clients should contact their Regional Manager. For assistance, contact Customer Service.

Test Classification
This test was developed and its performance characteristics determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

CPT Code Information
82088

LOINC® Information

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<th>Test ID</th>
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<th>Order LOINC Value</th>
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<table>
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<tbody>
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