Primary Aldosteronism

Screening, confirmatory testing, subtype localization, and medical/surgical treatment of primary aldosteronism.

2025 Endocrine Society
Primary Aldosteronism Clinical Practice Guideline
Adler et al. · JCEM 2025;110:2453–2495

GRADE · 1 · Strong For · 2 · Suggest For · 2- · Suggest Against · Ungraded / Best Practice

1 Screening

2 Screen **all hypertensive individuals** for primary aldosteronism (PA).

2 Screen with **AM seated aldosterone + renin** (no dietary sodium restriction beforehand); check potassium to aid interpretation (low K can falsely lower aldosterone). **Positive screen:** suppressed renin (PRA ≤1 ng/mL/h or DRC ≤8.2 mU/L) + aldosterone ≥10 ng/dL (immunoassay) or ≥7.5 ng/dL (LC-MS/MS), AND ARR >20 (or >70 pmol/mU).

2 Confirmatory Testing

2 Use **PA-specific therapy** (medical or surgical) rather than nonspecific antihypertensives once PA is confirmed.

2 **Aldosterone suppression testing** when screening suggests PA and lateralization is unknown; can be skipped if lateralizing PA is obvious or if PA likelihood is so low that formal confirmation isn't justified.

3 Subtype Localization

2 **CT + adrenal venous sampling (AVS)** before deciding medical vs. surgical treatment in surgical candidates — exception: unilateral APA is highly likely (age <35, marked PA + hypokalemia, >1 cm unilateral adenoma on CT).

2 **Dexamethasone suppression test** in PA with an adrenal adenoma — a positive test prompts further Cushing syndrome evaluation.

4 Treatment

2 Base therapy on **lateralization + surgical candidacy**: unilateral adrenalectomy for lateralizing PA in surgical candidates; lifelong MRA for bilateral PA, unknown lateralization, or non-surgical candidates.

2 **Spironolactone** preferred as initial MRA (low cost, wide availability) — all MRAs have similar efficacy when dose-equivalent. Monitor potassium, renal function, renin, and BP to guide titration.

2 **MRAs preferred over ENaC inhibitors** (amiloride, triamterene) for PA-specific medical therapy.

5 Monitoring & Titration

2 If BP remains **uncontrolled and renin stays suppressed** on MRA therapy, **increase the MRA dose** to raise renin toward the pretreatment baseline.

Adler GK, Stowasser M, Correa RR, et al. Primary Aldosteronism: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab.* 2025;110(9):2453–2495.