Quest Diagnostics®

Primary aldosteronism

Don’t miss **primary aldosteronism** in your patients with hypertension

Primary aldosteronism (PA) is a condition that can lead to serious health complications if patients aren’t diagnosed. **Endocrine Society guidelines recommend all patients with hypertension be screened for PA**, but <1% of all patients with hypertension and only 1.6% of patients with resistant hypertension are screened.[1]

Primary aldosteronism can often go undiagnosed[2]

~120M
people are hypertensive in the US[3]

Up to 30% of people
with hypertension have PA[1]

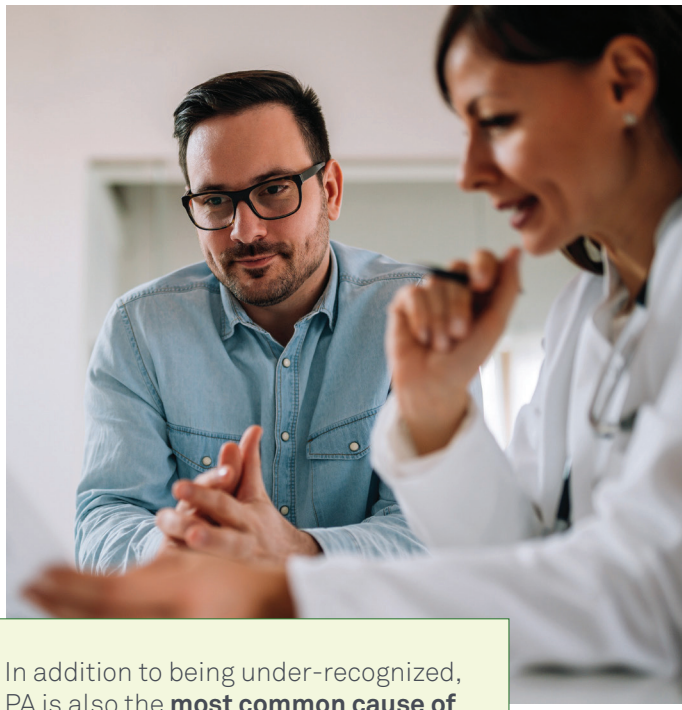
<1% of patients
with hypertension are screened for PA[3]

Understanding the relationship between hypertension and primary aldosteronism

PA is caused by the **overproduction of aldosterone**, a steroid hormone, by one or both adrenal glands.[4]

- Aldosterone regulates blood pressure by balancing sodium and potassium levels and water retention in the bloodstream[4]
- In PA, excess aldosterone is produced in a renin-independent way[4]

Elevated aldosterone causes the kidneys to absorb excess sodium and excrete more potassium, leading to increased sodium levels, water retention, and increased blood volume, which in turn results in severe hypertension.[4,5]



In addition to being under-recognized, PA is also the **most common cause of secondary hypertension**[3]

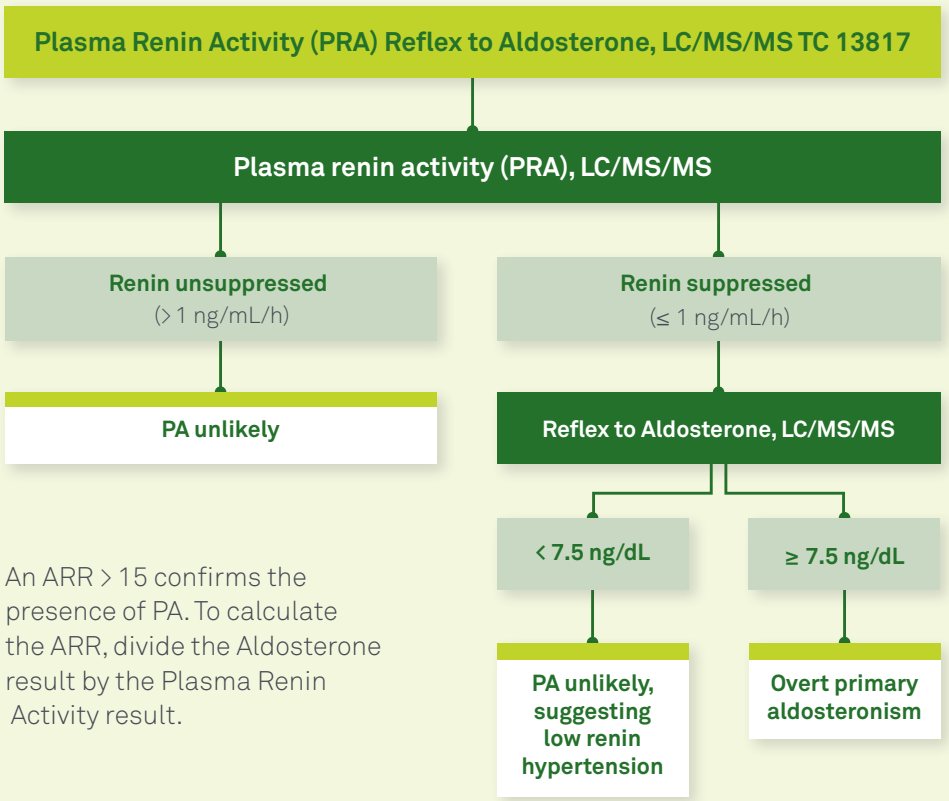
The 2025 Endocrine Society clinical practice guidelines on primary aldosteronism suggest that **all patients with hypertension** be screened for PA.[1]

The importance **of screening**

Patients with untreated PA are at a disproportionately **higher risk of cardiovascular, kidney, and metabolic disease** when compared to patients with primary hypertension.

These conditions include but are not limited to heart failure, kidney disease, stroke, atrial fibrillation (AF), myocardial infarction, type 2 diabetes mellitus (T2DM), and sleep apnea.[4,5]

Quest's solution for **primary aldosteronism screening**



An ARR > 15 confirms the presence of PA. To calculate the ARR, divide the Aldosterone result by the Plasma Renin Activity result.

Considerations **prior to testing:**

- Assess potassium levels if not performed recently; low potassium may lead to a false positive for low aldosterone[6]
- Patient should cease mineralocorticoid receptor antagonist (MRA) or Epithelial Sodium Channel (ENaC) inhibitor use for 4 weeks prior to avoid interference with the renin-independent pathway[6]

Test interpretation:

1. If the result of Plasma Renin Activity (PRA) is suppressed (ie, ≤ 1 ng/mL/min)
2. and, the result of Aldosterone is ≥ 7.5 ng/mL
3. and, the Aldosterone Renin Ratio (ARR) value is > 15
4. ✓ then, the patient meets criteria for primary aldosteronism based on the 2025 Endocrine Society clinical practice guidelines.[1]

The guideline recommends that patients who are diagnosed with primary aldosteronism should receive treatment specific to the condition. These treatment options include medications or surgery. Consult the full practice guidelines for more detailed information.[1]

Quest Diagnostics test	Test code	CPT® code
Plasma Renin Activity (PRA) Reflex to Aldosterone, LC-MS/MS *If renin is suppressed, Aldosterone, LC/MS/MS (test code 17181) will be performed at an additional charge (CPT code: 82088)*	13817	84244
Plasma Renin Activity, LC/MS/MS	16846	84244
Aldosterone, LC/MS/MS	17181	82088
Potassium, Serum	733	84132

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Visit **QuestDiagnostics.com/PrimaryAldosteronism** or contact your Quest Diagnostics sales representative for more information.

To speak to an endocrinology specialist, call 1.866.MYQUEST (1.866.697.8378).

References

1. Adler GK, Stowasser M, Correa RR, et al. Primary aldosteronism: an Endocrine Society clinical practice guideline. Endocrine Society. July 14, 2025. Accessed August 7, 2025. https://www.endocrine.org/clinical-practice-guidelines/primary-aldosteronism-2 **2.** Hundemer GL, Vaidya A. Primary aldosteronism diagnosis and management: a clinical approach. *Endocrinol Metab Clin North Am*. 2019;48(4):681-700. doi:10.1016/j.ecl.2019.08.002 **3.** CDC. Division for Heart Disease and Stroke Prevention. CDC-Million Hearts®. Hypertension cascade: hypertension prevalence, treatment, and control estimates among US adults aged 18 years and older applying the criteria from the American College of Cardiology and American Heart Association's 2017 Hypertension Guideline—NHANES 2017–2020. Updated May 12, 2023. Accessed September 3, 2024. https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html **4.** Cleveland Clinic. Primary aldosteronism (Conn's syndrome). Updated July 22, 2024. Accessed September 3, 2024. https://my.clevelandclinic.org/health/diseases/21061-conns-syndrome **5.** Hung A, Ahmed S, Gupta A, et al. Performance of the aldosterone to renin ratio as a screening test for primary aldosteronism. *J Clin Endocrinol Metab*. 2021;106(8):2423-2435. doi:10.1210/clinem/ dgab348 **6.** Funder JW, Carey RM, Fardella C, et al. Case detection, diagnosis, and treatment of patients with primary aldosteronism: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2008;93(9):3266-3281. doi:10.1210/jc.2008-0104

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Test codes may vary by location. Please contact your local laboratory for more information.

The CPT® codes provided are based on American Medical Association guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

This document is provided for informational purposes only and is not intended as medical advice. A healthcare provider's test selection and interpretation, diagnosis, and patient management decisions should be based on their education, clinical expertise, and assessment of the patient.

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