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When to Screen for Cushing's Syndrome: Smart & Strategic Screening Approaches

Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Fleseriu:

This is CME on ReachMD, and I'm Dr. Maria Fleseriu. Here with me today is Dr. Martin Reincke. Let's dive right in with a discussion of the importance of screening our patients for Cushing's syndrome.

Martin, the most important questions are who do we screen, and when do we need to screen them.

Dr. Reincke:

Thank you, Maria. The first and initial question is whether the patient has endogenous or exogenous Cushing's syndrome. So exogenous Cushing's syndrome results from any use of glucocorticoids taken orally, inhaled, or administered as injections or used topically in creams or ointments. That has to be excluded before you start thinking of endogenous Cushing's syndrome. Endogenous Cushing's syndrome is rather rare, whereas exogenous is very, very frequent. So 3% to 6% of the general population is taking steroids at a given time.

Endogenous Cushing's syndrome is caused either by a pituitary corticotroph adenoma secreting ACTH [adrenocorticotrophic hormone], it can be caused by ectopic ACTH secretion through a neuroendocrine tumor, or it can be caused by an adrenal adenoma. However, when do we suspect that there's endogenous Cushing's syndrome? Well, the main symptoms are changes at the skin, psychiatric comorbidity, metabolic comorbidities like diabetes and hypertension, but also osteoporosis at young age just to mention a few. However, this endogenous Cushing's syndrome has to be separated from nonneoplastic physiological endogenous hypercortisolism. That can be, for example, the case in endogenous depression, it can be the case in somebody chronically using alcohol in large quantities, and in many other situations. These both conditions, endogenous Cushing's syndrome and nonneoplastic physiological hypercortisolism, are not easy to distinguish, and sometimes time is helpful to observe a patient and to control those other conditions like metabolic complications, endogenous depression, or even stopping alcohol drinking in order to see whether it's true Cushing's or this pseudo-Cushing's state.

Dr. Fleseriu:

Thank you. I think we need more than an hour to discuss about all this, but the key point would be if you think about Cushing's, then the patient has to be screened for Cushing's. The likelihood of having Cushing's is essential in determining which test you need and how long to go in ruling in or ruling out. And then, besides screening, the confirmatory testing is also very important too. If the comorbidities you were talking earlier are not well-controlled, then we have to wait until we do the testing. And then, furthermore, do not do localization testing, like where the Cushing's is coming from, until we are sure that a patient has confirmed Cushing's. So do not miss cases; do not overdiagnose it either. Somewhere in between to make sure that we reach every patient and diagnose if they have Cushing's to improve their outcomes.

Well, this has been a great bite-sized discussion. Thank you, Martin, and thank you all for listening.

Dr. Reincke:

Thank you.

Announcer:

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