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Shared Decision-Making in Cushing's Disease

Announcer:
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Dr. Fleseriu:
This is CME on ReachMD, and I'm Dr. Maria Fleseriu. Here with me today is Dr. Richard Auchus.

When selecting therapy, it's important to engage patients in discussions about the benefits as well as potential risks and how to prevent them. Rich, the easiest question ever: How do you individualize therapy selection for Cushing's disease and discuss potential adverse events with your patients?

Dr. Auchus:
Well, gee thanks for that easy question, Maria. So I think the 3 things that I think about are the disease characteristics, which include sort of the predictive factors of how likely someone will respond to the treatment; the patient preference, injectable versus oral and so on; and also comorbidities from either the Cushing's or from other disease. So I think, you know, with our choice of drugs, those are kind of the main things.

And, so when we monitor patients on treatment, we want to monitor for the positive effects, for the improvements in the hypercortisolemia, both biochemically and clinically. We want to look for the associated electrolyte and blood pressure and glucose problems that may get worse or may get better on treatment, monitoring electrolytes and blood pressure and glucose, looking for QT prolongation in drugs that can do that, monitoring the EKG, and then keeping an eye on tumor recurrence, which we have to do periodically with MRI scans.

Now I think one very important aspect is in mitigating the glucocorticoid withdrawal syndrome during medical therapy. So just like when people get surgical remission for Cushing's, the rapid drop in hypercortisolemia can precipitate withdrawal symptoms, myalgias, poor sleep, depression, mood changes of other sorts. And people really need to be warned that this can happen. The best way to mitigate these problems are to really titrate the medication slowly after you warn the patients that they may happen. So remember, any dose of medication you give a patient is going to make them better than what they were before, but giving them too much can precipitate symptoms or frank adrenal insufficiency, which is not going to do them any good in the long term.

So we always take our time, tell people that you're going to feel a little sick, you're going to not feel like eating, and that that's okay. This is what the medication is supposed to do. You'll get through it. And then wait until they're tolerating this dose before we go to higher doses.

I think those are the main points that I consider in deciding what to give people, how to monitor them, and how to prepare them for what's coming.

Dr. Fleseriu:

I completely agree with everything you said. From my point of view, sometimes it's even hard to differentiate between glucocorticoid withdrawal syndrome and adrenal insufficiency. So if I'm not sure, I think of this as adrenal insufficiency and treat. For all the medications as well as for surgery, I tell the patients, if you have adrenal insufficiency, that means that what we did is working, but we'll try to avoid. So they leave our clinic with also prescriptions for glucocorticoids to use when we have suspicion for adrenal insufficiency. We'll check a cortisol before if we can, but if the patients are far from our laboratory, sometimes we can't do that. And we treat and then we'll talk more through them. The discussion to diagnose withdrawal takes time. And it's very important for the patients to have this access to us to talk through and try to understand which symptoms are worse than others. Fatigue is significant. Sometimes the myopathy gets worse and then we just have to dial down on the doses.

In the long-term studies that we did for adrenal steroidogenesis inhibitors, we showed, for example, that we had to decrease the dose for some of the drugs over time. So even if the patients are doing well at the beginning, they still might have events later on. So I think this is very important that somebody that had Cushing's, they have to be followed for long term, lifetime, immediately after surgery, also for recurrence, even if the patients are on medications, we need to monitor for efficacy but also for adverse events, sometimes even with MRIs later on if we see any tumor growth, or EKG for a QT prolongation.

But I wanted to emphasize that the large majority of adverse events in the prospective clinical trials happened relatively at the beginning. And I think some of them were due to us, especially the hypercortisolism-related events, because we increased the dose too fast. So patience is also key.

This has been a brief but great discussion. Thank you so much, Rich. Our time is up. And thanks everybody for tuning in.

Announcer:
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