

CUSHING'S SYNDROME IN PREGNANCY: A DIAGNOSTIC DILEMMA

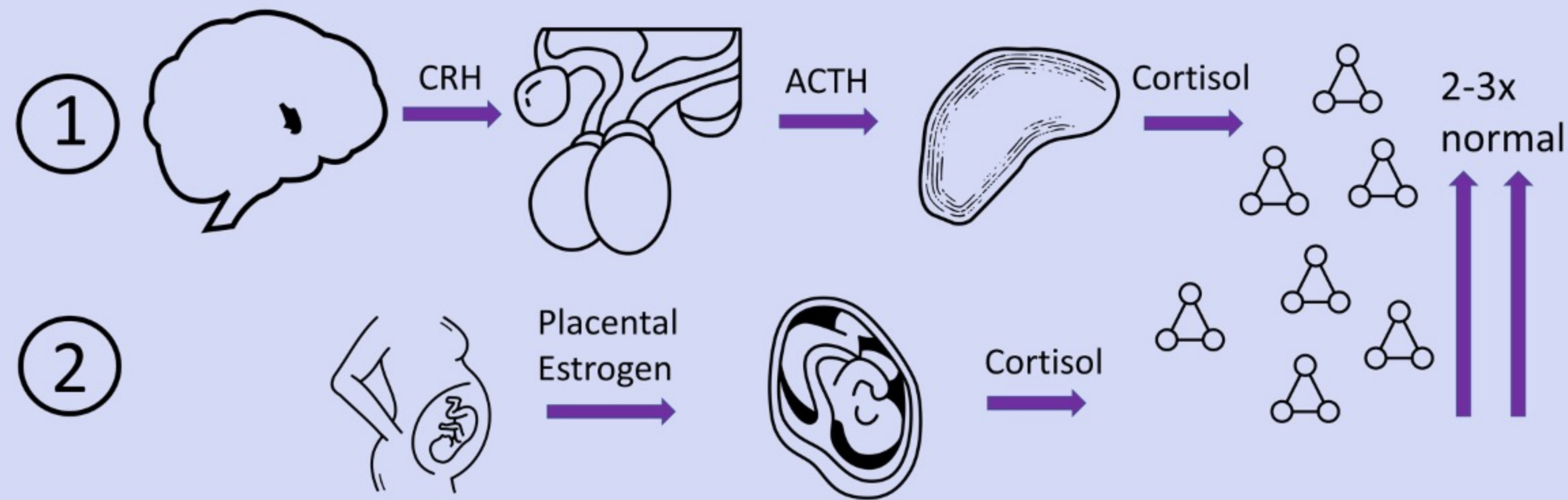
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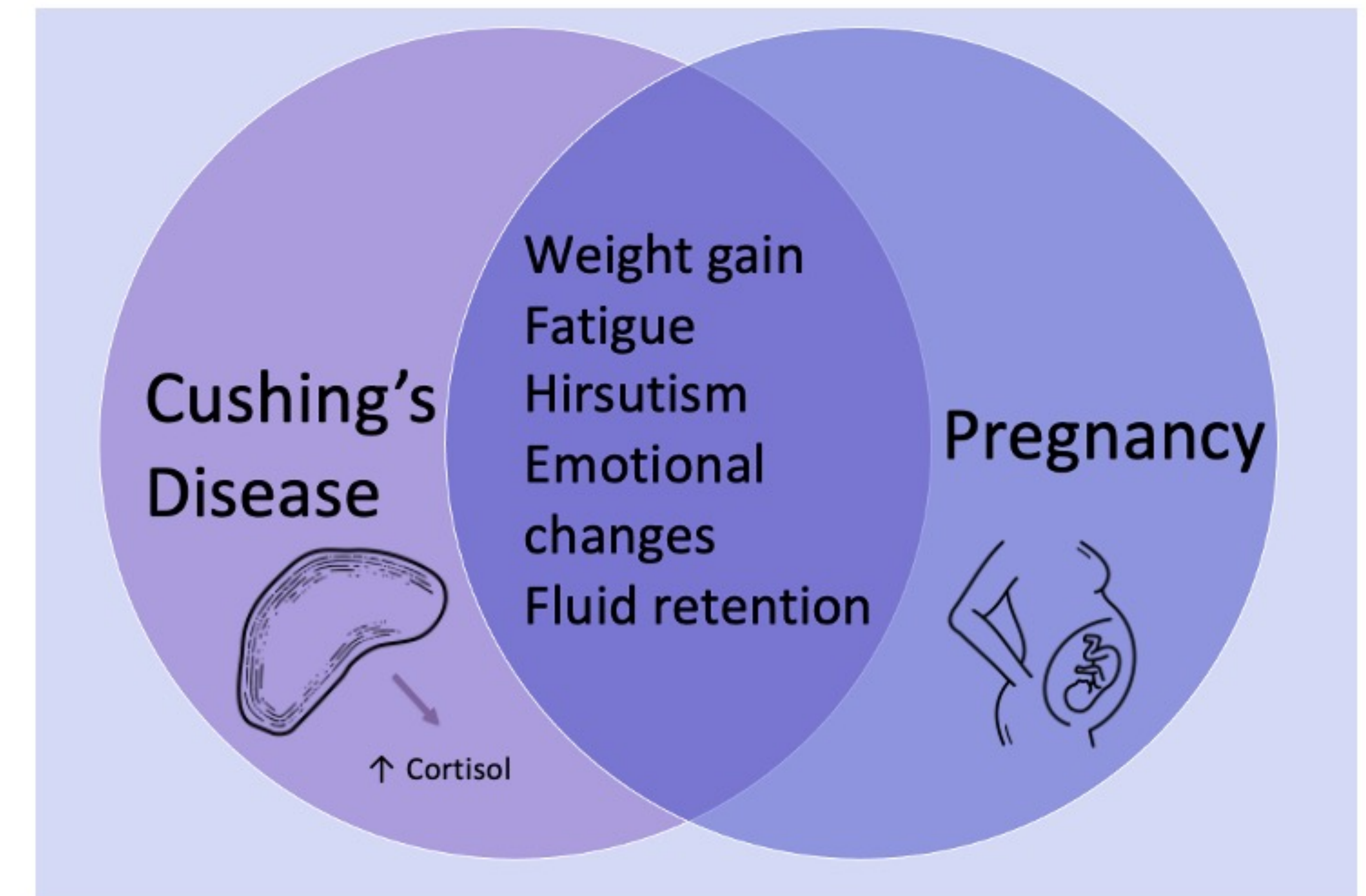
Background:

Cushing's syndrome is rare in pregnancy as Hypothalamus-Pituitary-Adrenal (HPA) dysfunction is associated with **infertility**

PATHWAYS FOR CORTISOL PRODUCTION



① Hypothalamus-Pituitary-Adrenal Secretion of Cortisol ② Pregnancy-induced Cortisol Production



Case Presentation & Hospital Course

History

- 36-year-old G4P2 at 23 weeks gestation
- New severe hypertension, hypoxia, fatigue, anxiety, edema, and hirsutism
- History of **adrenal mass** (without follow-up)

Physical

- **BP 164/81**, HR 87, **SpO2 94% on 5L NC**, RR 20, Temperature 36.9 °C
- 2+ pitting **edema** to the knees, + lung crackles

Evaluation

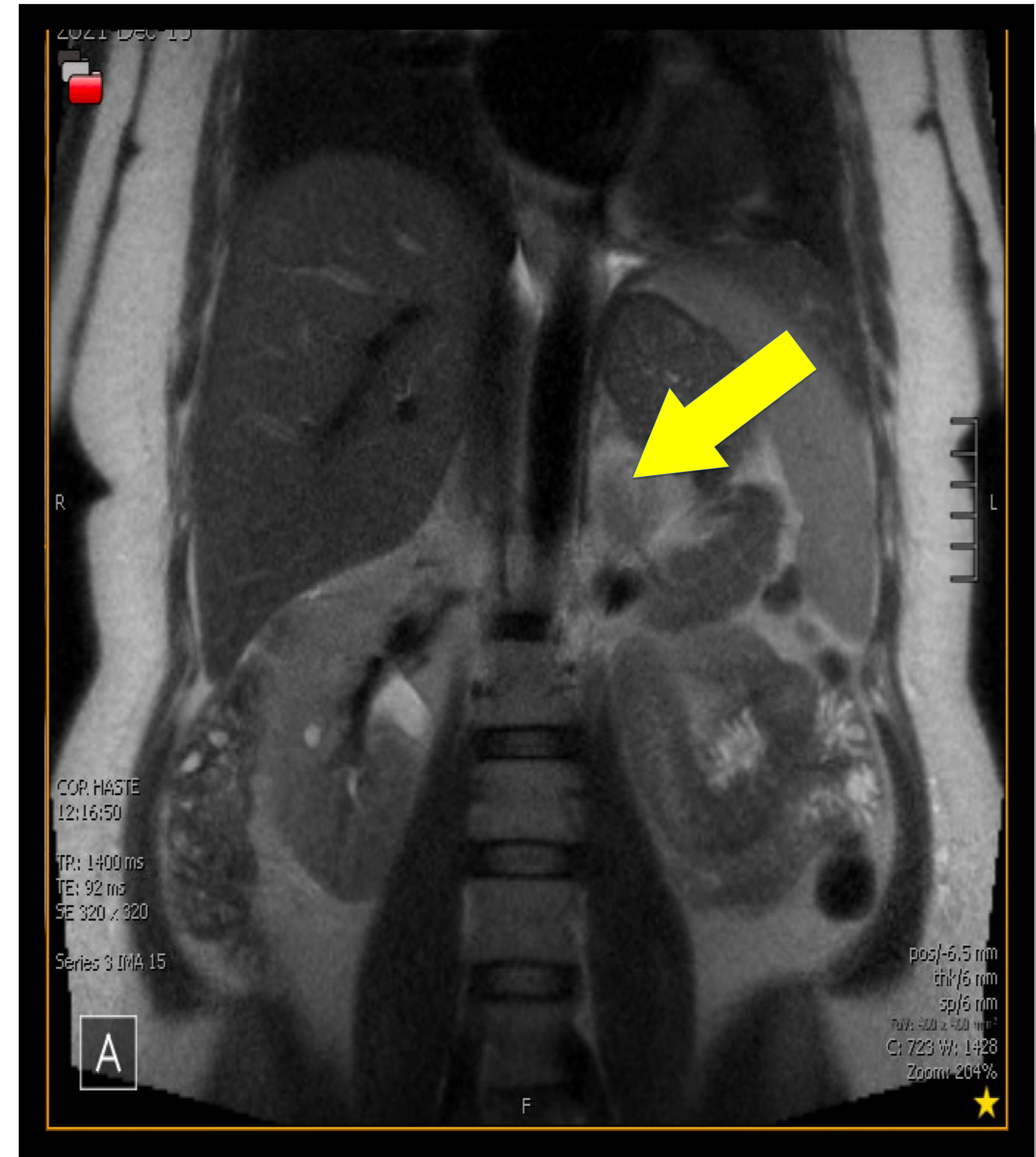
- Free urine **cortisol** ↑ (2186, nl <50), ACTH undetectable
- Plasma metanephrines undetectable x3
- AST/ALT ↑, K⁺ 2.4
- MRI abdomen: **3.5cm L adrenal nodule with interval growth**

Diagnosis

- Pre-eclampsia with severe features?
- Cortisol-secreting adrenal adenoma?
- Pheochromocytoma?

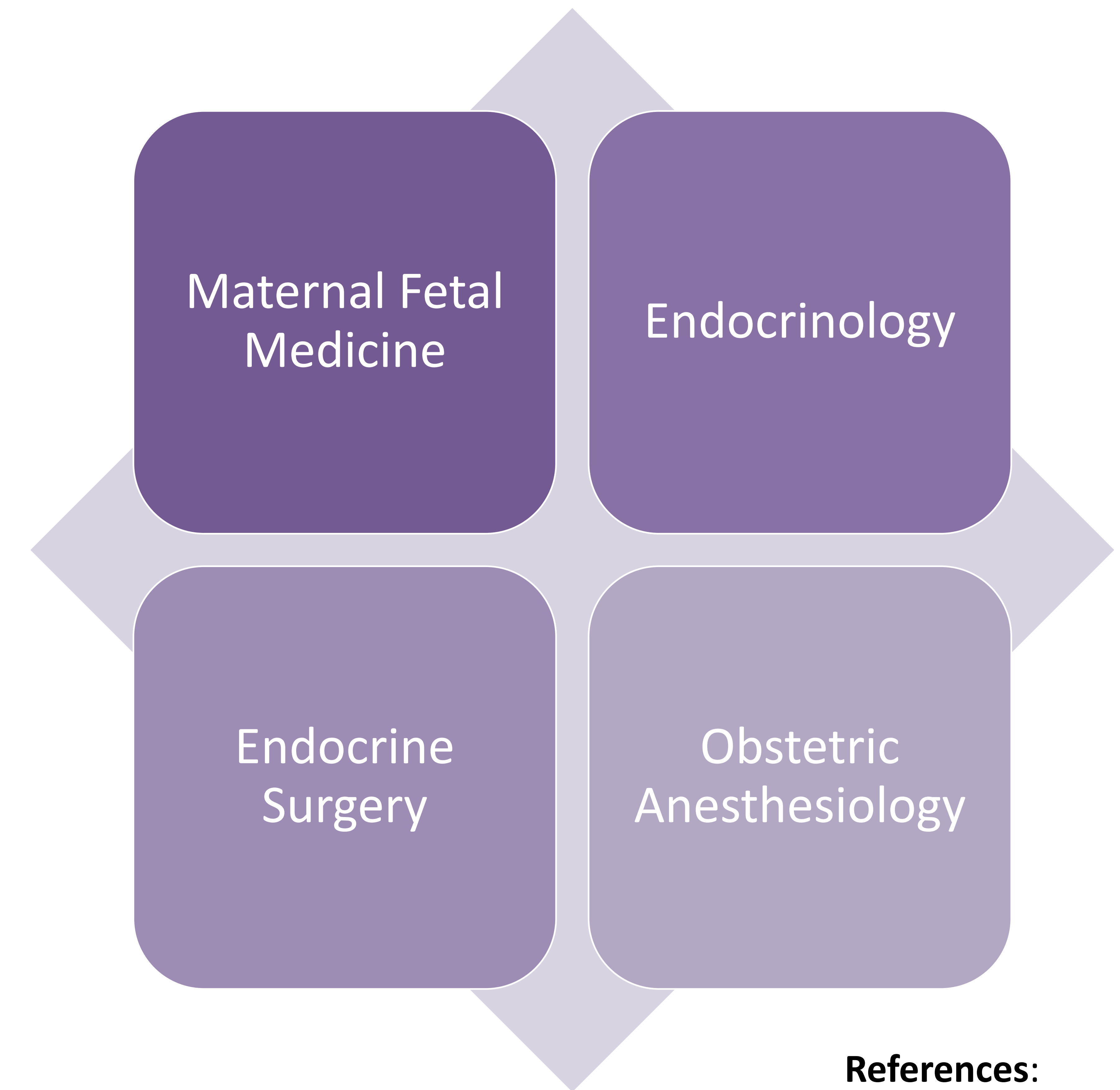
Management

- Patient optimization: diuretics, antihypertensives
- Uncomplicated laparoscopic **adrenalectomy** under general anesthesia
- Pathology: **cortisol secreting adrenal adenoma**
- Post-op: pain management, steroid taper, resolution of hypertension
- Full term delivery



Key Points:

- **Multidisciplinary care** is essential to diagnosis and management
- Prompt workup and maintaining a **broad differential** is important
 - Endocrine tumors can mimic pregnancy symptoms
 - Pre-eclampsia in the 2nd trimester is unusual
 - Electrolyte disturbances are uncommon in pregnancy
- Timing of the surgical intervention should be weighed against the safety of the parturient and the fetus



References:



Lindsay (2005) Endo Rev. 26(6): 775-799.



Sammour (2012) Euro J. Obstet Gynec. 165(1): 1-7.