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## Cushing's Syndrome Comorbidities: A Case Study of Interdisciplinary Collaboration

### 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 work through a case, Martin. Let's consider a 41-year-old woman who's been diagnosed with PCOS [polycystic ovary syndrome], prediabetes, and depression. Her primary care is suspicious that the patient might have Cushing's syndrome. What advice would you give to a clinician on how to screen, diagnose, and then when to potentially refer this patient?

### Dr. Reincke:

Thank you, Maria. That's a typical patient in an outpatient clinic setting where it might be Cushing's syndrome, but it might be also something else. So first of all, taking the history and careful examination of the patient is of most importance. Why? Because there are additional symptoms and signs in Cushing's, in a patient who truly has Cushing's syndrome, which you should be aware of. This is, of course, all the skin changes; it may be myopathy; it could be also the history of fractures. The more symptoms are there, the higher is the pretest probability of Cushing's. So if you have high pretest probability that the patient might really have Cushing's, then the next step is biochemical confirmation. And for that you have 3 tests. It's the salivary cortisol at late night; it's the urinary free cortisol; it's a dexamethasone suppression test. All 3 tests are excellent, but we use them according to the situation of the patient. For example, a night shift worker, there, the late-night salivary cortisol is useless, more or less, because it investigates the diurnal rhythm. Whereas in female patients, like the mentioned 41-year-old, if she is on the contraceptive pill, then the dexamethasone suppression test is not the best. Therefore, in my practice, late-night salivary cortisol is mostly the test we start with. And we not only take one, we take several of the samples.

You should consider referring a patient if you are puzzled by the test results or the clinical presentation, if you really don't know whether it's Cushing's or not. And also, you should refer those patients who are severely sick. How do you know that a patient is severely sick? When there are metabolic complications which are not easy to control, like uncontrolled hypertension, uncontrolled diabetes, infections, or very high cortisol levels, then this is a patient who should be at an expert center.

### Dr. Fleseriu:

I think that's very important, and I do the same thing. If somebody is asking me or refers me a patient that they thought about Cushing's, then that patient has to be screened for Cushing's. It doesn't mean the patient will have Cushing's. But for example, we did a study and half of the patients of women of young age that had Cushing's disease confirmed at surgery had been told for 4 to 5 years that they have PCOS. So this is very important to think both sides. Go through screening and definitely confirmatory testing because a lot of the comorbidities could be actually due to PCOS or diabetes or hypertension, for example, and not Cushing's. But it's important to rule out. Do we have to rule out in all patients? No. But if somebody is thinking about Cushing's – and what you said is the most important thing –

it's a corollary of signs and symptoms, not just numbers. So this is number one. Then, if sometimes we're not sure, time will tell us. So what I tell patients is one test was normal. If you have worsening of these symptoms, then you have to be retested again because a proper diagnosis is necessary. And then sometimes, especially if it's depression or other uncontrolled comorbidities, this can increase cortisol per se. So I recommend appropriate treatment for all of them and control with medication or other treatments. Normalize blood pressure, normalize glucose, treat depression, and then retest again if I think that the test would be positive.

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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