# Cushing's disease clinical features

The most common symptoms of a corticotroph tumor include weight gain, high blood pressure, diabetes, muscle weakness, and fatigue. Other symptoms may include menstrual irregularities, depression, anxiety, and changes in appearance (such as a round, “moon-shaped” face).

Diagnosis of a corticotroph tumor typically involves blood tests to measure ACTH and cortisol levels, as well as imaging studies such as magnetic resonance imaging (MRI) or computed tomography (CT) scans. Treatment options may include surgery to remove the tumor, radiation therapy, or medications such as cortisol synthesis inhibitors like osilodrostat.

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Cushing's name is commonly associated with his most famous discovery, Cushing's disease. In 1912 he reported in a study an endocrinological syndrome caused by a malfunction of the pituitary gland which he termed “polyglandular syndrome.” He published his findings in 1932 as “The Basophil Adenomas of the Pituitary Body and Their Clinical Manifestations: pituitary Basophilism”.

Cushing's disease (also known as Cushing disease, tertiary or secondary hypercortisolism, tertiary or secondary hypercorticism, Itsenko-Cushing disease) is a cause of Cushing's syndrome characterized by increased secretion of adrenocorticotropic hormone (ACTH) from Pituitary Corticotroph Adenoma (the anterior pituitary secondary hypercortisolism), leading to excess glucocorticoid and hypercortisolism.

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Common features of Cushing's disease are weight gain, hypertension, diabetes, poor short term memory, irritability, excess hair growth (women), red-ruddy face, extra fat around the neck, round face, fatigue, poor concentration, and menstrual irregularity in addition to muscle weakness. Some of the less common features include insomnia, recurrent infection, thin skin and stretch marks, easy bruising, depression, weak bones, acne, balding (women), hip and shoulder weakness, violaceous striae, hypokalemia, unexplained osteoporosis, diabetes mellitus, and swelling of feet/legs [1].

A clear difficulty of diagnosing CD seems that patients describe isolated symptoms to the family physician (FP) or the respective specialists according to their fields of specialization. Since FPs are contacted most frequently, they should be trained to recognize the broad spectrum of CD symptoms especially in female patients with weight gain and initiate endocrinological referral [2].

Due to the deleterious sequelae of delayed diagnosis, information programmes in the medical community are of paramount importance [3].

Weight gain

Chronic Glucocorticoid (GC) exposure in CD patients may stimulate the drive to eat by enhancing craving, rather than regulating the sensation of hunger. Continued alterations in appetite regulation due to abdominal fat mass and circulating cortisol could play a role in the cardiovascular and metabolic risk that has been reported in CD patients despite remission [4]

Hypertension

Ecchymoses

Amenorrea

Hyperpigmentation

Thin skin

Psychiatric manifestations

Osteoporosis

Muscle wasting

Adrenal hormone elevation

Sepsis

1)
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2)
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3)
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