Pituitary corticotroph adenoma diagnosis

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Pituitary MRI can localize microadenoma in only 50–60% of the cases as the size of the lesion is very small [1].

Although, dynamic studies have improved the sensitivity of MRI, it still fails to localize the adenoma in many cases [2].

High Dose Dexamethasone suppression test (HDDST) has low sensitivity (65%) and specificity (60%) in predicting Cushing's disease [3].

Bilateral inferior petrosal sinus sampling (BIPSS) series has shown the sensitivity of 88–100% and specificity of 67–100% in the localization of the Cushing's disease [4].

The prediction BIPSS of for lateralization of the lesion in Cushing's disease has been questioned, with accuracies ranging from 50% to 100% [5].

Bilateral inferior petrosal sinus sampling (IPSS) with corticotropin-releasing hormone (CRH) is currently the gold standard in the diagnosis of Cushing's disease (CD) and has also been used in tumour lateralization.

To establish a definitive Pituitary corticotroph adenoma diagnosis in the context of pre-existing chronic kidney disease, the absence of circadian rhythms of cortisol and ACTH is a more sensitive indicator than 24-hour urinary free cortisol (24-UFC) and low-dose dexamethasone suppression test [6].

1)
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6)

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