Cushing’s disease (CS) is caused by prolonged supraphysiological levels of circulating cortisol. Cushing’s disease (CD) is the most common etiology (70%–80% of CS cases) of endogenous CS. It is caused by a pituitary adenoma that secretes adrenocorticotropic hormone (ACTH), which stimulates secretion of cortisol by the adrenal glands. If not effectively treated, CD is associated with hypertension, diabetes, obesity, osteoporosis, vascular disease, and shortened life span. Successful resection of the CD-associated ACTH-secreting pituitary adenoma results in immediate biochemical remission with preservation of pituitary function. Accurate and early identification of CD is critical for effective surgical management and optimal prognosis. The authors review the current pathophysiological principles, diagnostic methods, and management of CD.

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KEY WORDS Cushing’s disease; diagnosis; surgery; treatment; oncology

Cushing’s syndrome (CS) is caused by prolonged supraphysiological levels of circulating cortisol. Cushing’s disease (CD) is the most common etiology (70%–80% of CS cases) of endogenous CS. It is caused by a pituitary adenoma that secretes adrenocorticotropic hormone (ACTH), which stimulates secretion of cortisol by the adrenal glands. If not effectively treated, CD is associated with hypertension, diabetes, obesity, osteoporosis, vascular disease, and shortened life span. Successful resection of the CD-associated ACTH-secreting pituitary adenoma results in immediate biochemical remission and preservation of pituitary function. Early identification of CD by clinical findings, endocrinological evaluation, and imaging studies is critical for diagnosis and effective surgical management.

Endocrinological and Clinical Features

Endocrinological Features

Normal Physiology

Insight into the normal and pathophysiological mechanisms of control of the hypothalamic–anterior pituitary–adrenal axis is critical to understanding the pathologic, diagnostic, and therapeutic features of CD (Fig. 1). Under normal physiological conditions (circadian rhythm, where cortisol levels peak in early morning and nadir late at night), systemic inflammation (cytokine), or stress (physiological or psychological), corticotropin-releasing hormone (CRH; a 41–amino acid peptide) is released from the paraventricular hypothalamic nucleus via the median eminence. From the median eminence, CRH is transported in the hypophyseal portal venous system to the pituitary gland, where it binds to the CRH receptor-1 (CRH-R1) on pituitary corticotroph cells. CRH binding to CRH-R1 receptors activates adenylate cyclase and stimulates proopiomelanocortin (POMC) gene expression in the corticotroph cells. Proopiomelanocortin preprohormone is processed into ACTH (a 39–amino acid peptide) and β-lipotropin (a 93–amino acid peptide). Products of β-lipotropin include β-endorphin and α-lipotropin. ACTH is secreted into the systemic circulation and binds to receptors in the adrenal cortex, where it stimulates production and secretion of glucocorticoids, including cortisol. Under normal conditions, circulating cortisol provides physiological control of this endocrine axis by its negative feedback inhibition on hypothalamic CRH and pituitary ACTH secretion.
Cushing’s disease

CD Pathophysiology

CD is caused by a benign monoclonal pituitary corticotroph adenoma that secretes excessive ACTH,39 which causes supraphysiological secretion of glucocorticoids from the adrenal glands. The excess circulating cortisol disrupts the normal physiological diurnal variation in cortisol levels and exerts negative feedback inhibition on CRH secretion from the hypothalamus. However, the adenoma itself is relatively resistant to inhibition by endogenous circulating cortisol (Fig. 1). Consequently, CD is associated with suppressed secretion of CRH and elevated levels of ACTH in relation to the degree of cortisol production.

Clinical Features

Epidemiology

CD has a prevalence of 39.1 per million inhabitants (incidence 1.2–2.4 newly diagnosed cases per 1 million persons per year).31,55 The average age at diagnosis for adults is in the 4th decade (younger in females [mean 30.5 years] than males [mean 37.1 years]). The average age at diagnosis in pediatric CD is approximately 13 years (symptom onset 10.6 years).50,58,60 Symptom initiation to diagnosis averages 2–3 years in pediatric and adult cases.58,113 Before puberty, the ratio of female-to-male cases is similar (1:1).50,58 In adult CD patients, females are more frequently affected than males (3:1 vs 5:1).20,82,105,113

Psychiatric deficits (depression, emotional liability, anxiety, psychosis, panic attacks, suicidal ideation, and paranoia) and neurocognitive deficits (learning impairment and memory deficits) can also be associated with CD and may be the only sign/symptom in a subset of patients.51,69

CD-Associated Morbidity and Mortality

CD-associated morbidity includes cardiac and cerebrovascular events, immunosuppression, osteoporosis, psychiatric disturbances, and diabetes. Untreated CD has an estimated standardized mortality ratio (ratio of observed CD-related deaths to expected deaths in the general population) of 1.9–4.821,31,40,55,111 CD-associated morbidity risk factors are substantially reduced with successful treatment,21,42,102 but effectively treated patients may have a higher frequency of diabetes, obesity, and dyslipidemia.

FIG. 1. Hypothalamic-pituitary-adrenal axis in healthy individuals and CD patients. **Left:** Under normal physiological circumstances, including circadian rhythm (diurnal secretion that peaks in early morning and nadirs near midnight) and stress (physiological and psychological), the paraventricular nucleus of the hypothalamus releases CRH (orange arrows), which the hypophysal portal venous system transports to the anterior pituitary gland. In the pituitary gland, CRH stimulates pituitary corticotroph cells (orange arrow) by binding to CRH-R1 receptors to stimulate production and excretion of ACTH into the systemic circulation. ACTH then stimulates the adrenal cortex (red arrow) to synthesize and secrete glucocorticoids, including cortisol. Cortisol inhibits this endocrine axis (blue arrows) at the hypothalamus and pituitary by binding to glucocorticoid receptors and reducing CRH and ACTH production/secretion, respectively. **Right:** Under the pathophysiological conditions associated with CD, a benign monoclonal basophilic adenoma of the anterior pituitary gland continuously (resulting in loss of normal diurnal secretory rhythm) secretes excess levels of ACTH (large red arrow). Circulating ACTH drives supraphysiological production and secretion of cortisol from the adrenal cortices (large blue arrows) that results in reduced CRH production/excretion by the hypothalamus. While the ACTH-secreting adenomas in CD retain CRH-R1 and vasopressin receptors with their associated stimulatory capacity (adenomas secrete ACTH [large red arrow] when stimulated by CRH or desmopressin [large blue arrows]), the cortisol-driven negative feedback on the pituitary is significantly blunted. Nevertheless, very high levels of exogenous steroid (e.g., high-dose dexamethasone test response) suppress ACTH production by CD adenomas (small red arrow) and downstream circulating cortisol levels (small blue arrows). Copyright OSU Health Sciences Library Medical Visuals. Published with permission.
compared with controls. While many studies indicate that CD-associated mortality is returned to general population rates after biochemical remission, other studies have shown an elevated cardiovascular risk of death up to 5 years after successful biochemical remission. Psychiatric and neurocognitive disturbances can persistent in some patients after successful treatment. Patients with persistent CD after treatment suffer increased morbidity and mortality.

Diagnosis

Biochemical Diagnosis

Diagnosis of CS

After exogenous sources are ruled out, clinical suspicion of CS leads to laboratory assessment to confirm the presence of endogenous hypercortisolism (Fig. 3). Established guidelines for the diagnosis of CS recommend verification of hypercortisolism by 2 screening tests. Screening tests include late night salivary cortisol, 24-hour urine free cortisol, or low-dose dexamethasone suppression (1 mg overnight or 2 mg over 48 hours) testing.

Establishing the Cause of Hypercortisolism

After the diagnosis of CS is established, its cause is sought. Endogenous hypercortisolism can be caused by either an ACTH-dependent (pituitary adenoma or ectopic tumor) or independent (adrenal tumor) mechanism (Fig. 3). Plasma ACTH levels are obtained to assess for ACTH dependency as the cause of hypercortisolism. Inappropriately elevated ACTH levels in a hypercortisolemic state (i.e., greater than 10 pg/ml) are consistent with an ACTH-dependent cause (Fig. 3).

After the isolation, sequencing, and synthesis of CRH by Vale and colleagues in 1983, CRH stimulation was introduced as a diagnostic test for the differential diagnosis of ACTH-dependent causes of CS (Fig. 1). This strategy was based on the assumption that CD is caused by well-differentiated adenomas derived from pituitary corticotrophs and that these adenomas should have receptors for CRH and the cellular constituents necessary to respond to CRH stimulation (a positive response is set arbitrarily at a 50% or more increase in ACTH and 20% or more increase in cortisol). Alternatively, ectopic ACTH-secreting tumors are derived from nonpituitary tissues and generally do not respond to CRH. However, there is an approximately 10% incidence of false-negative and false-positive results in ectopic tumors with CRH stimulation testing.

High-dose dexamethasone suppression testing also can be used to distinguish between ACTH-dependent causes of CS. This strategy was based on the assumption that CD is caused by well-differentiated adenomas derived from pituitary corticotrophs and that these adenomas should have receptors for CRH and the cellular constituents necessary to respond to dexamethasone (suppression) in the pituitary adenoma corticotroph cells and the lack of the negative feedback response in ectopic nonpituitary tumors that secrete ACTH (Fig. 1). In this manner, high doses (8 mg) of dexamethasone can suppress cortisol (i.e., a 50% or more decrease) secretion in approximately 80% of CD patients but the majority of ectopic ACTH-secreting tumors typically do not respond. However, a significant overlap in responses of pituitary and ectopic tumors to high-dose dexamethasone suppression testing compromise the diagnostic accuracy of this test.

MR Imaging

Because of their potent biological/clinical effects, CD-associated pituitary adenomas are often discovered when they are small. Data from large surgical series indicate that over 90% of ACTH-adenomas are microadenomas (< 1 cm in diameter) with a mean diameter of 6 mm at time of diagnosis. However, the small adenoma size and a reduced signal-to-noise imaging ratio at the sella–sphenoid bone–air interface contribute to the 40%–60% lack of detection of CD-associated adenomas on MR imaging at time of clinical and biochemical diagnosis. To best
detect CD-associated adenomas on MR imaging, spoiled gradient recalled (SPGR) acquisition MR sequences are used. High-resolution (1- to 1.5-mm slice thickness) SPGR MR imaging enhances detection of ACTH-secreting pituitary adenomas by 15%–30% compared with other available MR imaging sequences (Fig. 4).\textsuperscript{7,18,81}
FIG. 4. Coronal postcontrast MR images of the pituitary gland in a 6-year-old boy with CD. Preoperatively, standard T1-weighted (left) and SPGR MR (right) images were performed. While T1-weighted MR imaging did not reveal an adenoma, SPGR MR imaging clearly demonstrates a 3-mm adenoma (right, arrowheads). At surgery, an adenoma was found precisely in the location revealed by SPGR MR imaging. Complete resection was achieved, resulting in biochemical remission.

Inferior Petrosal Sinus Sampling

Diagnostic Evaluation

The pituitary gland drains laterally into the cavernous sinuses and then into the inferior petrosal sinuses. ACTH has a short half-life that results in an ACTH concentration gradient between the inferior petrosal veins and the peripheral blood. Consequently, more concentrated blood can be sampled from the direct venous drainage of the pituitary (via the inferior petrosal veins) compared with sampling from the systemic venous system. To better enhance central to peripheral differences in pituitary secretory substances (including ACTH), CRH stimulation was introduced during inferior petrosal sinus sampling (IPSS). Combining IPSS with CRH stimulation reduced the incidence of false-negative findings compared with systemic sampling.73

Since the cavernous sinus blood often remains on one side as it enters the petrosal venous system, sampling from only one petrosal sinus has limited diagnostic utility.28,34,75 A combination of facts (i.e., the increased sensitivity of detecting ACTH secretion from a corticotroph adenoma, the stimulation response of the adenoma to CRH, and the potential for the venous blood to remain on one side of the inferior petrosal sinus in many patients) leads to the introduction of CRH stimulation with bilateral simultaneous IPSS for the differential diagnosis of CS. Furthermore, because of the frequent ipsilateral lateralization of pituitary gland drainage, lateralization of ACTH concentration in the inferior petrosal sinuses identified by bilateral assessment can also assist in the lateralization of adenoma within the pituitary gland in some cases (see IPSS Lateralization for Localization of ACTH Adenomas in CD below).34,75

While false-negative and false-positive results are associated with IPSS, most diagnostic errors with IPSS are false-negative results in CD patients who do not have a central-to-peripheral concentration gradient (ratio of central-to-peripheral ACTH levels) of basal ACTH that is 2.0 or more, or 3.0 or more after CRH stimulation.33,45,80,93,110 This is often a result of unsuccessful placement of the intravascular catheter tips in the inferior petrosal sinuses. To avoid this problem, proper placement of intravascular catheter tips can be routinely confirmed by retrograde venography of the cavernous sinuses and inferior petrosal sinuses. The consistency of success with bilateral sampling of the inferior petrosal sinuses is operator dependent and varies substantially from center to center, from nearly universal success at some centers33,38,110 (including pediatric patients) to success rates of 67%–84% at others.99,96

Most CD patients with a false-negative result can be identified by their relatively low peak ACTH levels in the inferior petrosal sinuses blood (less than 200 pg/ml basal levels or less than 400 pg/ml after CRH stimulation).75,110 The relative concentration of prolactin in the inferior petrosal sinuses blood compared with the peripheral blood can be used to normalize the concentration of the ACTH from the inferior petrosal sinuses in relation to the peripheral blood to yield a calculated ACTH in the inferior petrosal sinuses–to–peripheral blood ratio that can enhance the diagnostic accuracy of the test.33,65,93 For this reason, many centers save blood samples from the procedure and measure the prolactin concentrations if the results of the IPSS need further analysis. To avoid false-positive results, IPSS must be performed while the patient is hypercortisolemic. If IPSS is performed in the absence of sustained hypercortisolism, the normal corticotrophs are not suppressed and will respond to CRH. The resulting inferior petrosal sinus–to–peripheral ACTH gradient will suggest CD, regardless of the etiology of CS and in normal subjects.80,112 Thus, during the eucortisolemic phase of cyclic CS or while under medical therapy to block cortisol production, false-positive results occur.

The initial results of IPSS for the differential diagnosis of CS suggested that the diagnostic accuracy of IPSS was 100%.34,75 However, later experience from many centers has indicated that, although the test is the most accurate endocrine test for the differential diagnosis of ACTH-dependent CS, it is now generally accepted to have a diagnostic accuracy in the range of about 95% at most institutions with a large CS experience.33,49,80,93 Although the largest experience with bilateral IPSS is with CRH stimulation, corticotroph tumors also respond to desmopressin, which can be used for the test if CRH is unavailable (Fig. 3).16,59

IPSS Lateralization for Localization of ACTH Adenomas in CD

In the first small series, it appeared that bilateral IPSS (indicated by a side-to-side basal ratio of 1.4 or more) would permit prediction of the side of the pituitary gland that contained an ACTH-secreting microadenoma.51,72 However, later experience has shown that the lateralization accuracy of the test is in the range of 70%75,110 and the highest predictive value for lateralization is associated with consistent lateralization before and after CRH stimulation.110

Complications of IPSS

Venous infarction of the brainstem with permanent, serious neurological deficits can occur during IPSS.38,64 Thus, most centers of expertise in the evaluation and treatment of CS use IPSS only in patients with ACTH-dependent CD and conflicting results of noninvasive endocrine evaluation for the differential diagnosis of CS, discordant biochemical and radiological studies, or negative pituitary MR imaging (Fig. 3).80

Cyclical CS and CD

Since the report by Liddle and colleagues in 1973,12 it
has been apparent that the exceptionally rare patient with clinical features of CS may have cycles of excess glucocorticoid production that occurs every few days, weeks, or months. During cycles of normal cortisol production, endocrine testing to establish the diagnosis of CS or the differential diagnosis of it can be misleading. Consequently, it is important to recognize the potential diagnostic dilemma associated with such patients, especially since cyclical CS may accompany CD, ectopic ACTH-producing tumors, or cortisol-secreting adrenal tumors. The diagnostic strategy in cyclical CS is clinical follow-up with repeated testing, relying on testing midnight salivary cortisol and 24-hour urine free cortisol testing, rather than dexamethasone suppression testing.

Surgical Treatment

Selective Adenomectomy

Successful adenomectomy eradicates the ACTH-secreting adenoma and immediately eliminates excess cortisol production while maintaining normal pituitary function (Fig. 5). Consequently, the initial treatment recommendation for CD is surgery. While some centers advocate medical therapy before surgery to reverse the effects of
hypercortisolism, preoperative medical therapy complicates postoperative evaluation and is rarely necessary. Since 2010, surgical series generally show remission rates between 65% and 85% and recurrence rates of 10%–35% (Table 1).1–3,5,8,20,24,25,27,41,44,53,86,97,99,101,107 Surgical success and recurrence rates depend on surgeon experience, as well as the criteria used to define cure and length of follow-up.

Factors Affecting Surgical Outcome

Most of the emphasis on surgical technique for pituitary tumors over the past 30 years has been on approaches to the pituitary (sublabial, endonasal, endoscopic, and/or microscopic),62 instead of the details of how best to remove the tumor with most consistent success. Nevertheless, 3 factors influence the likelihood of successful surgery, including preoperative MR imaging findings, dural invasion by the adenoma, and adenoma size.

Preoperative MR Imaging Findings

Preoperative adenoma identification on MR imaging is associated with higher odds of finding the adenoma at surgery (18-fold higher) and postresection biochemical remission (4-fold).19 When an adenoma is seen on MR imaging, it directs surgical exploration to the adenoma location within the pituitary (86% correlation between MR imaging and surgical findings).110 A critical feature associated with successful surgical treatment, cavernous sinus dural invasion, is not well detected on MR imaging. Only 22% of cavernous sinus wall invasion cases in CD are accurately detected by MR imaging.57 An MR imaging–invisible adenoma often can be found in CD patients by systematic exploration of the pituitary gland via a series of incisions carried deeper in stages.77,92 When adenomas reach a diameter of approximately 3 mm, a surrounding microscopic tissue envelope develops that corresponds to a rim of compressed gland adjacent to the edge of the adenoma (histological pseudocapsule) that can be used to identify small adenomas, invade small dural folds, and facilitate selective enucleation of both small and large adenomas.46,58,77 Selective adenomectomy using the histological pseudocapsule to define the boundaries of the adenoma achieves immediate and lasting remission in 97% of adult and 98% of pediatric CD patients.36,58

Adenoma Dural Invasion

Persistent hypercortisolism after adenoma resection can result from dural invasion, which usually occurs laterally into the cavernous sinus wall. If dural invasion is limited to partial thickness invasion of the cavernous sinus wall, invaded portions of dura can be removed safely, resulting in biochemical remission.26,57 When the adenoma extends through the dural wall and invades the cavernous sinus, lasting curative surgery is unlikely, even with apparent complete removal of the tumor from the cavernous sinus.

Adenoma Size

When adenomas are so small that they cannot be located during pituitary gland exploration, a portion (partial hypophysectomy) or all (total hypophysectomy) of the anterior lobe may be removed. Partial hypophysectomy involves either removal of 70%–80% of the anterior pituitary lobe, leaving 20%–30% attached to the pituitary stalk, or removal of half of the anterior lobe corresponding to IPSS lateralization. Partial and total hypophysectomies have similar biochemical remission rates (60% to 80%) (Table 2).2,11,29,42,85,104 While partial hypophysectomy permits most patients to retain normal pituitary function, pituitary function is permanently abolished after total hypophysectomy.

Risks of Surgery

Risks of operative therapy for CD (2%–10% morbidity, less than 2% mortality) are similar to surgery for other pituitary tumors and include vision loss, other cranial nerve injury, vascular injury, loss of pituitary function, diabetes insipidus, delayed hemorrhage, and cerebrospinal fluid leakage.20,58,98 Because of the small size of most adenomas in CD, these risks occur less likely than after surgery for larger pituitary tumors.

<table>
<thead>
<tr>
<th>Authors &amp; Year</th>
<th>No. of Patients</th>
<th>Remission</th>
<th>Mean Follow-Up (yrs)</th>
<th>Recurrence</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Overall</td>
<td>Hypocortisolemic</td>
<td>Eucortisolemic</td>
</tr>
<tr>
<td>Alahmadi et al., 2013</td>
<td>42</td>
<td>28 (67%)</td>
<td>22 (79%)</td>
<td>6 (21%)</td>
</tr>
<tr>
<td>Alexandaki et al., 2013</td>
<td>124</td>
<td>84 (68%)</td>
<td>56 (45%)</td>
<td>28 (23%)</td>
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<td>Hameed et al., 2013</td>
<td>52</td>
<td>43 (83%)</td>
<td>13 (30%)</td>
<td>30 (70%)</td>
</tr>
<tr>
<td>Lambert et al., 2013</td>
<td>257</td>
<td>230 (89%)</td>
<td>195 (76%)</td>
<td>NR</td>
</tr>
<tr>
<td>Lonser et al., 2013</td>
<td>200</td>
<td>195 (98%)</td>
<td>189 (95%)</td>
<td>6 (3%)</td>
</tr>
<tr>
<td>Starke et al., 2013</td>
<td>61</td>
<td>58 (95%)</td>
<td>35 (57%)</td>
<td>23 (38%)</td>
</tr>
<tr>
<td>Wagenmakers et al., 2013</td>
<td>86</td>
<td>62 (72%)</td>
<td>NR</td>
<td>NR</td>
</tr>
<tr>
<td>Aranda et al., 2015</td>
<td>32</td>
<td>32 (78%)</td>
<td>12 (38%)</td>
<td>20 (62%)</td>
</tr>
<tr>
<td>Berker et al., 2013</td>
<td>90</td>
<td>81 (90%)</td>
<td>76 (94%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>Costenaro et al., 2014</td>
<td>103</td>
<td>84 (76%)</td>
<td>34 (40%)</td>
<td>NR</td>
</tr>
<tr>
<td>Dimopoulou et al., 2014</td>
<td>120</td>
<td>85 (71%)</td>
<td>65 (76%)</td>
<td>20 (24%)</td>
</tr>
</tbody>
</table>

NR = not reported.
* Adapted from Dallapiazza et al., 2015.

NR = not reported.
* Adapted from Dallapiazza et al., 2015.
Absence of Hypocortisolism After Surgery

Within 48 hours of surgery, most patients in remission from CD develop a glucocorticoid withdrawal syndrome associated with circulating cortisol levels of 2 μg/dl or less (see Measures of Biochemical Remission below). Alternatively, with persistence of hypocortisolism after surgery, the source of the unsuccessful surgery must be residual tumor that was not removed. Four factors influence incomplete tumor removal: 1) the removal of incidental adenomas (which occur in 15%–20% of pituitaries at autopsy but for unexplained reasons are much less likely to occur during surgical exploration in CD) rather than the corticotroph tumor(s) can occur; 2) mistakenly assuming an adenoma was found, resulting in the removal of a site that appears abnormal at surgery, but that proves to be normal gland on histological inspection; 3) incomplete removal of an ACTH-secreting adenoma contained within the pituitary; and 4) an invasive ACTH-secreting adenoma that was not recognized or incompletely removed at surgery can result in lack of biochemical remission.26,57

The first 2 causes of incomplete ACTH-secreting adenoma removal often occur in patients when complete exploration of the gland was not performed after the apparent adenoma was removed (Fig. 6). Early repeat surgery is an option in these cases with exploration of the unexplored portion of the pituitary in an attempt to find and remove the adenoma, or removal of a portion of the remaining anterior lobe if no tumor can be identified, as described above. If an ACTH-staining adenoma contained completely within the pituitary gland was identified but only partially removed at the initial surgery, the residual tumor is always in the same region. Repeat surgery offers an excellent chance of complete resection in these cases. Thus, early repeat surgery has a reasonable chance of curing the condition and preserving pituitary function in the first three circumstances.9,88,95 On the other hand, if the gland was completely explored at the initial surgery by an experienced surgeon, the chances of achieving remission by finding and selectively excising an ACTH-producing adenoma are remote. Additional surgery is rarely indicated in this circumstance.

Recurrence of CD After Initial Surgical Remission

Delayed (months to years after initial biochemical remission) CD recurrence represents growth of residual microscopic tumor at the site, or immediately adjacent to the adenoma resection site at the initial operation (Fig. 6). Similar to initial surgery, identification of recurrent adenoma on MR imaging guides surgery to the site of adenoma and predicts success of repeat surgery for recurrent CD.

Measures of Biochemical Remission

Determinates of lasting biochemical remission have not been defined. A variety of posttreatment criteria have been used to assess therapeutic success. Specifically, low (below 2 μg/dl) morning serum cortisol, low urine free cortisol levels (below 20 μg/24 hours), low serum ACTH (less than 5 pg/ml), and/or low midnight salivary cortisol within the 1st week have been used to predict lasting success.10,14,56,58 Recent data indicate that a morning serum cortisol level less than 1 μg/dl (on postoperative Day 3, 4, or 5 off of exogenous steroids) is the best predictor of lasting biochemical remission (96% positive predictive value). However, higher subnormal values do not exclude lasting remission. Dynamic testing, including CRH or desmopressin stimulation testing, can be used to predict biochemical remission but have not proven to be more effective in predicting long-term remission than basal serum cortisol levels.
ism, relative hypothyroidism, and low growth hormone dynamics resolve slowly over 6–12 months. Treatment for these endocrinological changes is individualized according to patient age and symptoms.

Pathologic Findings
Harvey Cushing originally described the adenomas associated with CD as basophilic adenomas. Immunohistochemistry of CD adenomas shows diffuse ACTH-positive tumor cells. Because complete adenoma removal results in profound hypocortisolism (24–48 hours after surgery in most patients), it seems counterintuitive that the normal pituitary gland corticotrophs would retain normal ACTH-positive staining. Nevertheless, the normal gland corticotrophs do maintain ACTH-positive staining in CD.
At centers that infrequently deal with CD patients, ACTH-positive staining of the normal pituitary gland corticotrophs can occasionally lead to an incorrect diagnosis of diffuse corticotroph hyperplasia. In turn, this can lead to total hypophysectomy if it is not recognized as the normal pattern of staining in the normal gland in CD patients. In a series of more than 1500 patients with CD, we have not encountered a case of diffuse corticotroph hyperplasia in the absence of ectopic production of CRH (a very rare cause of CD that is associated with corticotroph hyperplasia).

In 75%–80% of patients with chronic hypercortisolism of any etiology, the normal corticotrophs undergo changes in which the cytoplasmic granules are replaced with homogeneous hyaline material. These changes are histological changes known as Crooke’s changes. The presence of these changes is associated with the degree of hypercortisolism and individual susceptibility to them. The changes are never present in the absence of hypercortisolism. Consequently, their presence can be used to confirm that a patient in whom no signs of CS were seen on surgical exploration of the pituitary does, indeed, have CS. On the other hand, about 20% of patients with an ACTH-positive staining pituitary adenoma at surgery do not have Crooke’s changes and, therefore, the absence of Crooke’s changes does not establish the absence of CS.

Other Treatments

Medical Therapy

Medical therapy is the standard second-line treatment if surgery is not successful or if it is not possible. In these circumstances, medical therapy may be used adjunctively with radiation therapy to achieve eucortisolism while awaiting the therapeutic effects of radiation. Effectiveness of medical therapy (usually assessed by normalization of urine free cortisol levels) should be established before initiation of radiation treatment to avoid hypercortisolism while waiting for the effects of radiation. Medical therapies include steroidogenesis inhibitors, corticotroph-directed agents, and glucocorticoid receptor blockers.

Steroidogenesis Inhibitors

Steroidogenesis inhibitors, mitotane, ketoconazole, metyrapone, and etomidate block one or more steps of adrenal steroidogenesis of cortisol. Mitotane is typically not a first-line agent because the high rate of gastrointestinal side effects, long onset to action, and its teratogenic/abortifacient effects in women who desire pregnancy. Recently, a large retrospective study (200 patients) revealed that 49% of CD patients treated with ketoconazole achieved normalization of urine free cortisol levels (an additional 26% of patients had a 50% or more decrease). Gastrointestinal side effects, inhibition of testosterone production, and hepatic dysfunction (and rarely death) occurred. Metyrapone has also been used to successfully treat CD patients. Metyrapone has also been associated with gastrointestinal side effects and may exacerbate hyper tension/hirsutism by blocking 21-hydroxylase and increasing precursors to cortisol that have mineralocorticoid and androgenic activity. As a result, ketoconazole may be better suited to women and metyrapone to men. Rarely, parental etomidate (anesthetic induction agent) was used in refractory cases to rapidly reduce supraphysiological cortisol levels but requires careful dose-titr ation.

Corticotroph-Directed Agents

Pasireotide and cabergoline can inhibit ACTH production via binding to somatostatin and dopamine receptors expressed on corticotroph adenomas. Recently, pasireotide was found effective in reducing urine free cortisol levels (median 50% reduction) and associated clinical features. Common side effects included gastrointestinal symptoms, gallstones, and hyperglycemia. The latter occurred in approximately 75% of patients and may limit this drug’s use in patients with diabetes or glucose intolerance. Cabergoline reduces urine free cortisol levels in CD patients (40% partial and 35% complete response) but therapeutic escape occurs in 33% of patients after 6 to 18 months of treatment. Treatment was well tolerated and hypotension was the only serious side effect (13%). Steroidogenesis inhibitors have also been combined with these corticotroph-directed agents (in short-term use) to elicit biochemical control in 90% of CD patients.

Glucocorticoid Receptor Antagonist

The glucocorticoid receptor antagonist mifepristone can be used to block the peripheral effects of elevated cortisol, including hyperglycemia. While a recent study indicates that mifepristone increases ACTH (2-fold) in CD patients, short-term imaging data suggest that CD-associated adenomas do not progress on treatment. Because mifepristone increases ACTH and cortisol levels indirectly via peripheral glucocorticoid receptor blockade, there is no clear end point to follow regarding adequacy of the dose. Common side effects (nausea, fatigue, headache, and hypokalemia) are typically well tolerated and reversible, but antiemetic and abortifacient effects may preclude use in women who desire pregnancy.

Radiation Therapy

Radiation therapy has been used for treatment of patients with CD for several decades. Radiation therapy was a mainstay of treatment when the source of CD was originally being elucidated. More recently, stereotactic radiosurgery (SRS) approaches (i.e., Gamma Knife, linear accelerator, proton beam) that precisely target the region of treatment have been introduced. The optimal dose is 20–25 Gy for SRS and 45–50.4 Gy given over 5 weeks for radiation therapy. Generally, the incidence of remission in CD seems to be similar between the various forms of radiosurgery (43%–58%) and fractionated therapies (46%–84%; Table 3).

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Adrenalectomy

Because the adrenal cortices are the target organs of ACTH and the source of supraphysiological cortisol secretion in CD, bilateral adrenalectomy can be used to treat refractory cases of CD. Adrenalectomy is typically performed laparoscopically and produces biochemical remission in greater than 95% of refractory cases of CD. Bilateral adrenalectomy is associated with an 18% median morbidity rate within 30 days of surgery. There is a 28% median rate of adrenal crisis after bilateral adrenalectomy. Mortality associated with bilateral adrenalectomy has been estimated at 9% and is most frequently due to stroke and myocardial infarction.60

There is a 21% median rate of Nelson’s syndrome (pituitary adenoma progression with progressive elevation of ACTH due to lack of cortisol negative feedback) after bilateral adrenalectomy.60,61 Early data suggest the incidence and severity of Nelson’s syndrome is minimized by precedent postoperative (after pituitary surgery) radiation.60,61 Nelson’s syndrome can be treated by observation (for stable small tumors), tumor resection, tumor/sella radiation, and/or pharmacotherapy. Typically, resection of pituitary adenoma or hypophysectomy is the treatment of choice. If surgery is ineffective or not possible, tumor/sella radiotherapy or radiosurgery can be performed. Finally, pharmacotherapy is used as an adjunct to treat Nelson’s syndrome.79

Conclusions

Increased understanding and improved diagnostic paradigms have enhanced detection and diagnosis of CD. Today, most CD patients can be cured by surgery or successfully managed by surgery combined with adjuvant therapies.

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Correspondence
Russell R. Lonser, Department of Neurological Surgery, The Ohio State University Wexner Medical Center, 410 W 10th Ave., Doan Hall N1047, Columbus, OH 43210. email: russell.lonser@osumc.edu.

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