Cushing's syndrome due to autonomous macronodular adrenal hyperplasia: long-term follow-up after unilateral adrenalectomy

Mauro Boronat, Tomás Lucas, Balbino Barceló, Carmen Alameda, Hassan Hotait, Javier Estrada

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This report describes a case of Cushing's syndrome due to autonomous macronodular adrenal hyperplasia in which unilateral resection of the right adrenal resolved the Cushing's syndrome.

Keywords: Cushing's syndrome, suprarrenal hyperplasia, adrenalectomy

Endogenous adrenocorticotropic (ACTH)-independent Cushing's syndrome is caused by an autonomous adrenal production of cortisol. In most cases, it is due to a primary adrenal neoplasm, adenoma or carcinoma, usually unilateral. Rare nonmucinous primary adrenal processes that can also cause Cushing's syndrome are bilateral. They include pigmented micronodular adrenal dysplasia1 and autonomous macronodular adrenal hyperplasia (AMAH).2-4 We describe a patient with AMAH who was treated successfully by unilateral adrenalectomy.

Based on the short-term haemodynamic benefits of methylene blue in septic shock, we would encourage investigators to consider more prolonged administration of the drug.

Data on benefit and absence of toxicity can only be obtained through increased investigation.

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Autonomous macronodular adrenal hyperplasia

With the diagnosis of AMAH, the patient underwent right adrenalectomy. Owing to the concurrent history of cardiac and pulmonary diseases, bilateral adrenalectomy was considered to entail high risk and resection of the other gland was delayed for a further operation. The adrenal gland weighed 26.8 g and measured $5.5 \times 4.5 \times 3$ cm. Light microscopic examination revealed well-delimited benign hyperplastic nodules, which ranged in size from microscopic clusters of cells to 2 cm in diameter. The interstitial areas of the cortex did not show atrophy, but were also occupied by diffusely hyperplastic tissue.

Postoperatively, baseline plasma cortisol was 377.3 nmol/l (08.00 h) and 470.9 nmol/l (23.00 h), urinary free cortisol was 126.9 nmol/24 h and serum ACTH levels were undetectable. Signs and symptoms of hypocortisolism resolved some months later.

Although baseline plasma cortisol and urinary free cortisol always ranged within normal limits, studies of adrenocortical function at three, six and 12 months post surgery, and annually thereafter, continued to demonstrate persistent loss of cortisol rhythm, without suppression by high doses of dexamethasone. When last seen at the follow-up clinic, 10 years after adrenalectomy, basal plasma cortisol was 198.2 nmol/l (08.00 h) and 187.6 nmol/l (23.00 h), plasma ACTH was 1.23 pmol/l (08.00 h) and 1.07 pmol/l (23.00 h) and urinary free cortisol was 96.5 nmol/24 h. After overnight 16 mg oral dexamethasone administration, the morning plasma cortisol level was 204.1 nmol/l. Baseline plasma 11-deoxycortisol was 79.1 nmol/l and, 8 h after metyrapone administration, only rose to 329 nmol/l.

**Discussion**

Bilateral macronodular enlargement of the adrenals develops in 20–40% of patients with Cushing's disease and is thought to be caused by chronic hypersecretion of ACTH. However, a few cases of AMAH without a previous history of Cushing's disease have been convincingly documented.

In our patient, dynamic tests of adrenal function, suppressed ACTH levels and scintigraphic image suggested an autonomous adrenal hyperfunction. A diagnosis of AMAH was confirmed at pathological examination.

**Table** Pituatory-adrenocortical functional assessment

<table>
<thead>
<tr>
<th></th>
<th>Baseline levels</th>
<th>2 mg dexamethasone suppression</th>
<th>8 mg dexamethasone suppression</th>
<th>Metyrapone test (pre/post)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plasma cortisol</td>
<td>510.4–499.3*</td>
<td>620.7</td>
<td>786.3</td>
<td>–</td>
</tr>
<tr>
<td>(nmol/l)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary free cortisol</td>
<td>804.2</td>
<td>662.4</td>
<td>1445.7</td>
<td>–/190.9</td>
</tr>
<tr>
<td>(nmol/24 h)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary 17-hydroxycortico-steroids (nmol/24 h)</td>
<td>65.7</td>
<td>44</td>
<td>69.8</td>
<td>65.1/48.3</td>
</tr>
<tr>
<td>ACTH (pmol/l)</td>
<td>undetectable</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

*Samples at 08.00 h–23.00 h. **0.5 mg/6 h, for eight doses. †2 mg/6 h, for eight doses. ‡750 mg/4 h, for six doses
Since AMAH affects both glands, bilateral adrenalectomy appears to be the most appropriate and, to date, the only procedure to achieve surgical cure. Unexpectedly, in our case, a single adrenalectomy proved to be a successful treatment: cortisol secretion was reduced and the physical features of the patient regressed over subsequent months. During long-term follow-up hypercortisolism has never recurred and he is presently doing well. Postoperative outcome has revealed the remaining gland works autonomously, but it is not able to cause hypercortisolism. This striking functional profile persists 10 years after adrenalectomy.

It has been speculated that AMAH originates from a long-lasting stimulation by ACTH, ultimately becoming autonomous and suppressing pituitary ACTH release, on the basis of cases of single adrenal macronodules and coexisting pituitary lesions. We can find no evidence of this 'transition hypothesis' to explain our case. Other non-corticotropic factors can induce AMAH. Two cases have been shown to be due to inappropriate sensitivity of the adrenal glands to gastric inhibitory polypeptide. Likewise, local growth promoting factors have also been reported to exert a mitotic effect on adrenocortical cells in vitro.

Whichever the responsible growth factor in our case (systemic or paracrine), it prompted different reactions in each gland. It produced a more intense proliferative response in the right gland, with maintenance of autonomous, differentiated hypersecretion. In contrast, the left adrenal progressed to autonomous but normal-to-low secretion, perhaps suggesting that hyperplastic cells from that gland had lost part of their functional capacity.

Clonal analysis in several macronodules from a patient with AMAH, demonstrated that all the nodules of a gland had a monoclonal composition, whereas those removed from the larger contralateral gland had an intermediate polyclonal—monoclonal pattern. Moreover, studies in vitro showed that one of the monoclonal nodules only secreted cortisol precursors, while one of the mixed nodules was still able to secrete cortisol. This report showed that, in AMAH, adrenal nodules display not only variable secretory patterns, but also different genetic origin. It may also explain the discordant behaviour of the adrenal glands in our patient.

In conclusion, we describe a patient with Cushing's syndrome caused by AMAH in whom a right adrenalectomy removed the most important source of corticoids. Cushing's syndrome resolved and replacement therapy was never necessary.

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