

# CLINICAL CHARACTERISTICS AND FOLLOW-UP OF PATIENTS WITH ADRENAL INCIDENTALOMAS

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## BACKGROUND

The adrenal incidentalomas (AI), adrenal masses greater than 10mm in diameter incidentally detected, have increased their prevalence due to technological advances in imaging. The adrenalectomy is indicated in functioning adrenal tumors and in cases suspected of malignancy.

## OBJECTIVES

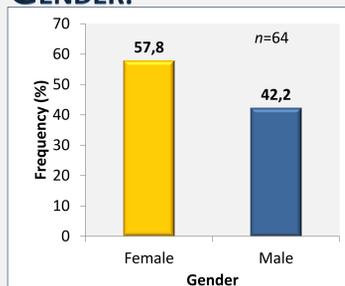
To analyze the characteristics of patients with AI and to evaluate the clinical outcome, in terms of evolution toward hypersecretion and significant growth, during follow-up over 5 years.

## METHODS

- Observational, descriptive and retrospective study
- **64 patients** with AI observed in our Department between January and October 2013
- **Significant growth:** tumor growth greater than 1 cm
- **Subclinical Cushing's Syndrome (SCS):** presence of at least two alterations among 1mg dexamethasone suppression test with cortisol above 3µg/dl, elevated urinary free cortisol (UFC) and ACTH below 10pg/ml
- **Statistical Analysis:**
  - IBM® SPSS® Statistics v. 20.0

## RESULTS

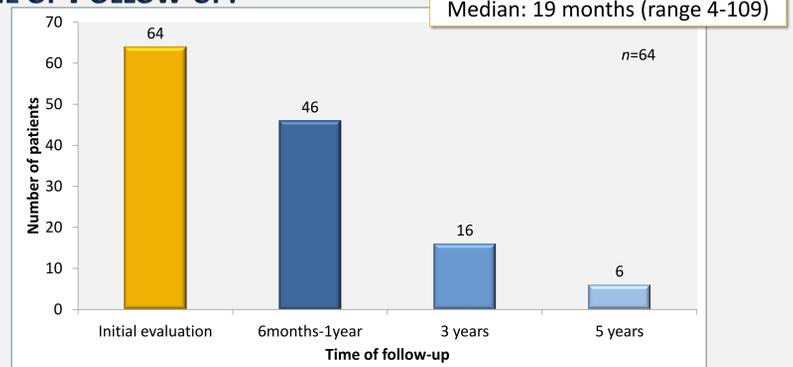
### GENDER:



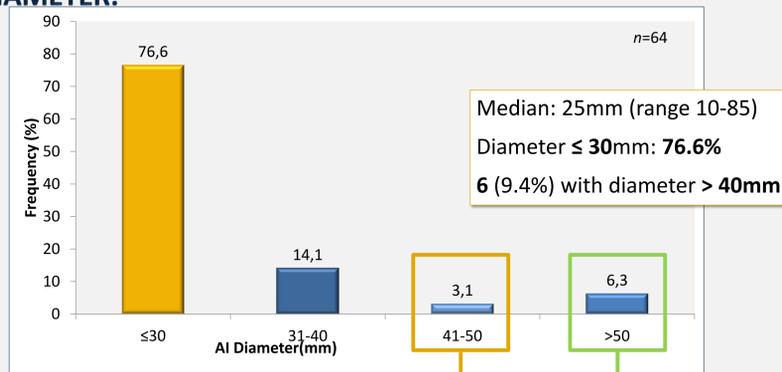
### AGE:

Mean (at diagnosis) **58.6±11.8 years**  
Range **30-83 years**

### TIME OF FOLLOW-UP:



### AI DIAMETER:



2 cases

Imagiologic features of adrenal myelolipomas

4 cases:

3 pheochromocytomas  
1 probable metastatic disease

### CLINICAL OUTCOME:

#### Hypersecretion

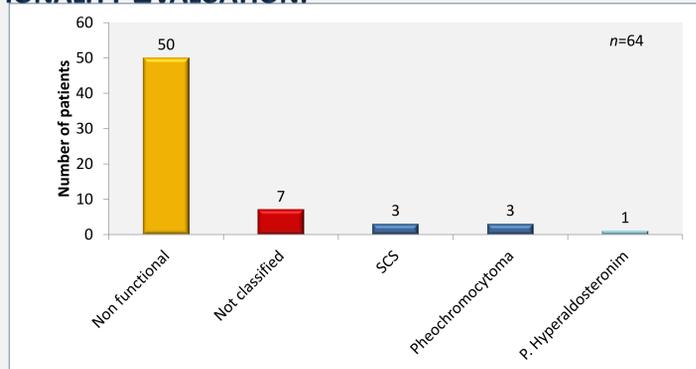
After 3 years of follow-up, **2 AI** acquired autonomous cortisol secretion (SCS)

#### Growth

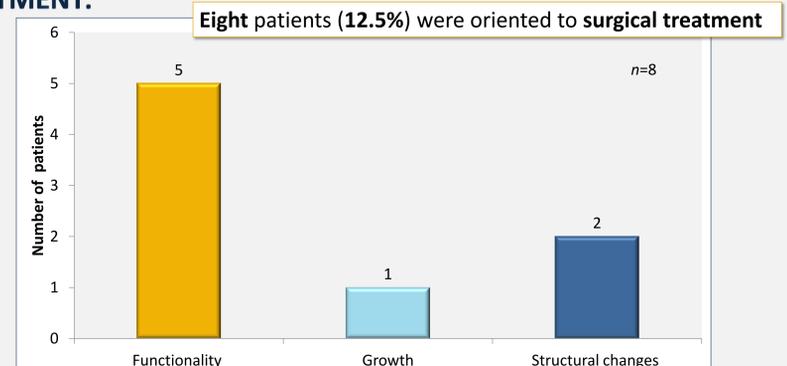
After 3 years of follow-up, **1 patient** had a **significant growth** of AI

- 10mm
- Imagiologic features of **myelolipoma**
- Not further growth

### FUNCTIONALITY EVALUATION:



### TREATMENT:



## CONCLUSION

Excluding myelolipomas, the AI greater than 4cm in diameter corresponded to hormonally active or malignant lesions, so adrenalectomy in these tumors seems undeniable. The percentage of AI which grew significantly and became active was low, therefore it's surely questionable the relevance of the long term follow-up of these patients.

## REFERENCES

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3. De Leo M. *et al*, Subclinical Cushing's syndrome, Best Pract Res Clin Endocrinol Metab. 2012, 26:497-505;
4. Terzolo M. *et al*, Subclinical Cushing's Syndrome: definition and management, Clin Endocrinol. 2012, 76:12-18.

## ACKNOWLEDGEMENTS

To the Portuguese Society of Endocrinology, Diabetes and Metabolism for the financial support to attend the 16<sup>th</sup> ECE