CUSHING'S DISEASE IN A PATIENT WITH COMPLICATED VARICELLA

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INTRODUCTION

Immunosuppression is a possible consequence of hypercortisolism, putting these patients in a state of increased risk of infections.

CASE REPORT

Identification: Female, 19 years old.

**BLOOD TESTS**

- **Fever + erythematous rash on face/trunk with subsequent widespread to the entire body (severe lesions on external ear)**

- **Hb 17g/dL, WBC 7.70x10^9/L, Platelets 75000**
- **Total Proteins 53.5g/L (64-83), Albumin 31.6g/L (38-51)**
- **AST 3478U/L (10-31), ALT 3491U/L (10-31), GGT 685U/L (7-32), AP 88U/L (30-120)**
- **TBil 1.01mg/dL (<1.2), DBil 0.55mg/dL (<0.4), DHL 6193U/L (135-225), CK 805U/L (10-149)**
- **Glucose 196mg/dL, Urea 14mg/dL (5-50), Creatinine 0.49mg/dL (0.51-0.95)**
- **Na 133mEq/L (135-147), K+ 3.1mEq/L (3.5-5.1), Cl- 101mEq/L (101-109)**
- **C-Reactive Protein 184.7mg/L (<3.0)**
- **aPTT 42.4sec (35.5), PT 17.4sec (14.0)**

**THORAX X-RAY**

- **Liver distended with increased dimensions (16cm longitudinal diameter at the mid-clavicular line), diffuse increased echogenicity and heterogeneous echo structure. Without dilatation of the bile duct. No other changes.**

**ABDOMINAL ULTRASOUND**

**INFEKTIOUS INTENSIVE CARE UNIT - DIAGNOSIS: SEVERE VARICELLA WITH ACUTE CHOLESTATIC HEPATITIS**

**COMPLEMENTARY DIAGNOSTIC TESTS**

- **Increased IgG (514mg/dL), normal IgA and IgM**
- **ANA, ANCA, AMA, anti-dsDNA, anti-KL, anti-smooth muscle negative**
- **Normal ceruloplasmin and copper; Ferritin 11786.1 ng/mL (N10-120)**
- **Echocardiogram: Small pericardial effusion, no signs of compression. No other changes. BNP 15.4 pg/mL**

**PERCUTANEOUS LIVER BIOPSY - Histology:** Acute cholestatic hepatitis with confluent necrosis of coagulative type, with morphological aspects corresponding to those described in VZV infection. Marked steatosis, predominantly macrovesicular.

**TREATMENT AND COMPLEMENTARY CLINICAL EXAM**

- **Aciclovir (750mg/day) Amoxiclav (8days)**
- **Vulvar, oropharyngeal/garyngeal candidiasis**
- **Hypokalemia, hypocalcemia, hypophosphatemia, vit. D deficiency**
- **Diabetes Mellitus (HbA1c 6.7%)**
- **High Blood Pressure**

**GRADUAL IMPROVEMENT OF INFECTIONAL CONDITION AND ASSOCIATED DYSFUNCTIONS**

- **Moon faces (particulary in the last 2 months)**
- **Wide purple striae**
- **Bruises**
- **Menstrual irregularities and secondary amenorrhea (menarche at 10 years)**

**SUSPECTED HYpercORTISOLISM → ENDOCRINOLOGY**

**Suspected high-dose dexamethasone suppression test**

<table>
<thead>
<tr>
<th>Time</th>
<th>Cortisol (ug/dL)</th>
<th>ACTH (pg/mL)</th>
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<tbody>
<tr>
<td>8h</td>
<td>26.0</td>
<td>81.0</td>
</tr>
<tr>
<td>24h</td>
<td>21.8</td>
<td>94.0</td>
</tr>
<tr>
<td>48h</td>
<td>3.8</td>
<td>28.5</td>
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**PITUITARY MRI**

“Lesion in the right half of the pituitary gland compatible with a microadenoma”

**BONE DENSITOMETRY**

- **Z-score - lumbar spine: -2.2 | femur: -1.2**
- **Lumbar spine: 23% lower than expected**
- **Femur: 14% lower than expected**

**DISCUSSION**

This clinical case emphasizes the importance of considering hypercortisolism as a condition capable of inducing immunosuppression, which may result in the development of serious infections and, therefore, these severe clinical situations should raise this diagnostic possibility.