

# Overview rationale and to suggest enlisting cushing's syndrome



OVERVIEW OF THE MEDICAL LITERATURE ON THE TOPIC The intention of the paper is to give rationale and to suggest enlisting Cushing's syndrome (CS) amongst high cardiovascular (CV) risk conditions. A considerable amount of data refers to several-fold amplified mortality in CS. The causes are based on high occurrence of many CV risk factors in persons with CS (e.

g., adiposity, arterial hypertension, dyslipidemia, as well as diabetes mellitus /DM/). Therefore, practically all individuals with CS have correspondingly the metabolic syndrome (MetSy), which is known as laden with high CV risk.

Characteristically, in spite of the young average age, numerous of CS individuals display a 'high' or a 'very high' CV risk, with the risk of a major CV event of over 20% in the following ten years. Although DM is listed as a condition with high cardiovascular risk CS is not, despite the fact that the greater part of CS population have either diabetes mellitus or diagnosed impaired glucose tolerance. CS is stated as a risk factor for aortic dissection in current guidelines, and it should be named as a disease with high CV risk (alike DM and chronic kidney disease) in the relevant guidelines, as well.

Key-Words: Cushing's syndrome, diabetes mellitus, arterial hypertension, metabolic syndrome, cardiovascular risk factors. Chronic corticosteroid administration (i. e. CS) is enlisted in 2010 Guidelines as a risk factor (RF) for aortic dissection with lack of detailed elucidation (1). Accordingly, what is evident both from common medical sense, as well as from everyday practice (that CS should be considered as a kind of high cardiovascular /CV/ risk) is not in Guidelines; nevertheless, what is neither noticeable, nor common (that CS

persons are predisposed to aortic dissection) is a part of current Guidelines (1).

The intention of the paper is to give rationale (from published medical literature) and to suggest enlisting CS amongst high cardiovascular risk conditions. OVERVIEW OF THE MEDICAL LITERATURE ON THE TOPIC Exogenous (mostly iatrogenic) CS is the repercussion of the applying of glucocorticoids or adrenocorticotropic hormone (ACTH). Iatrogenic CS is nowadays definitely the most frequent form of all forms of CS. In other words, as many as one percent of the populace is receiving corticosteroids per os (even 3% of individuals over 70 years old), plus individuals whose other administration routes (e. g., inhalation, transdermal, intravenous, intramuscular, intraarticular, rectal, etc) (2). While endogenous form of CS is practically rare, a markedly high percentage (0.

8-2%) of the overall population has long-term/high-dose glucocorticoid therapy (3). Wei et al. examined exactly 68,781 persons who were on glucocorticoid therapy, as well as 82,202 controls with lack of earlier hospitalization for CV illness (more than 150,000 individuals in whole). Independently of known covariates, estimated relative risk (adjusted rate ratio) for CV events, was 2.56 (CI, 2.18-2.

99) in individuals who have received glucocorticoids in high doses (4). This population-based research demonstrates that individuals who were treated with daily doses of glucocorticoids larger than 7.5 mg of prednisolone (or dose equivalents of other glucocorticoids) during one to five years of follow-up period, had significantly higher prevalence of all CV diseases, e. g.

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, myocardial infarction, cardiac insufficiency, as well as cerebrovascular illness(4). Since many individuals were administered corticosteroid therapy, it has a considerable clinical relevance (5)