Metastases

Metastases

Definition Adrenal metastases are not uncommon and often portend - disseminated incurable disease. Primary tumours that commonly spread to the adrenals include lung, renal, gastric, breast and colorectal cancers. The decision regarding surgical intervention must be multidis ciplinary and in conjunction with the patient, following careful diagnostic work-up to determine whether it is an isolated adre nal metastasis (seen most often with renal, lung and colorectal primaries) or a more widespread metastatic picture. Patients should therefore under go CT thorax, abdomen and pelvis and PET-CT to exclude disease at other sites. They should also be screened for catecholamine and cortisol excess to exclude a coincident hormonally active tumour. Treatment If disease is widespread, metastasectomy will not usually be appropriate and systemic or palliative treatment should be the norm. Adrenal metastasis diagnosed at presentation (synchro nous disease) should be removed if ipsilateral to a renal cell cancer (radical nephrectomy). In the case of other primary tumours, it should be observed with interval scanning at 3–6 months; if the lesion remains stable and isolated, resection should be considered. If adrenal metastasis arises more than 6 months after initial treatment (metachronous), PET-CT should be performed to exclude widespread disease; if the lesion is solitary , excision can be considered. Surgery Laparoscopic adrenalectomy is the preferred surgical option. Metastases often induce a significant desmoplastic reaction that can make excision more di ffi cult, particularly when lesions are >4 /uni00A0 cm. If there is evidence of local invasion, but the surgery is likely to improve survival, open surgery and bloc excision may be appropriate. Note that, in the setting of previous nephrectomy with adrenalectomy , excision of an Thomas Addison , 1795–1860, physician, Guy’s Hospital, London, UK, described the e ff ects of disease of the suprarenal capsules in 1852. Rupert Waterhouse , 1873–1958, physician, Royal United Hospital, Ba Carl Friderichsen , 1886–1979, Medical Superintendent, Sundby Hospital, Copenhagen, Denmark, gav steroid dependent. - -

TABLE 57.1 Causes and classi /f_i cation of adrenal insuf /f_i ciency. Cause of adrenal insuf /f_i ciency Pathophysiology Autoimmune adrenalitis (polyglandular Serum antibodies against the steroidogenic enzymes autoimmune syndromes) Infective tuberculous disease Caseating granulomatous destruction Bilateral adrenal infarction Severe bacterial sepsis in children, e.g. meningococcal septicaemia Bilateral adrenal haemorrhage Traumatic obstetric delivery Malignancy In /f_i ltration by secondary cancers Congenital adrenal hyperplasia (adrenogenital Genetic disorders of steroidogenesis syndrome) Pituitary destruction Infarction, trauma, haemorrhage or in /f_i ltration, e.g. craniopharyngioma Cessation of chronic glucocorticoid therapy Zona fasciculata and reticularis atrophy owing to long-term CRH suppression by exogenous corticosteroids Treatment of Cushing’s syndrome and Cushing’s CRH suppression following removal of ACTH-secreting or disease cortisol-secreting tumours Hypothalamic disorders Trauma, stroke, tumour in /f_i ltration, radiation, infection ACTH, adrenocorticotropic hormone; AI, adrenal insuf /f_i ciency; CRH, corticotropin-releasing hormone. a Waterhouse–Friderichsen syndrome.

Revision #1
Created 2025-12-31 15:21:19 UTC by Omar Ayman
Updated 2025-12-31 15:21:19 UTC by Omar Ayman