

01 - SECTION 1

Endocrinology

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Approach to the

Patient with Endocrine

Disorders The management of endocrine disorders has applied principles of precision medicine before the term was commonly used (Chap. 5). A general goal is to maintain or restore homeostasis using precise hormone measurements to titrate treatment regimens. Effective patient management requires a broad understanding of intermediary metabolism, reproductive physiology, bone metabolism, and growth. Accordingly, the practice of endocrinology is intimately linked to a conceptual framework for understanding hormone secretion, hormone action, and principles of feedback control (Chap. 389). The endocrine system is evaluated primarily by measuring hormone concentrations, arming the clinician with valuable diagnostic information. Most disorders of the endocrine system are amenable to effective treatment once the correct diagnosis is established. Endocrine deficiency disorders are treated with physiologic hormone replacement; hormone excess conditions, which usually are caused by benign glandular adenomas, are managed by removing tumors surgically or reducing hormone levels medically.

SCOPE OF ENDOCRINOLOGY

Classically, the specialty of endocrinology encompasses the study of glands and the hormones they produce. Over time, the field has expanded because of the discovery of hormones and growth factors produced by the brain, gastrointestinal (GI) tract, musculoskeletal system, and other nonglandular organs. The term endocrine was coined by Starling to contrast the actions of hormones secreted internally (endocrine) with those secreted externally (exocrine) or into a lumen, such as the GI tract. The term hormone, derived from a Greek phrase meaning “to set in motion,” aptly describes the dynamic actions of hormones as they elicit cellular responses and regulate physiologic processes through feedback mechanisms. Unlike many other specialties in medicine, it is not possible to define endocrinology strictly along anatomic lines. The classic endocrine glands—pituitary, thyroid, parathyroid, pancreatic islets, adrenals, and gonads—communicate broadly with other organs through the nervous system, hormones, cytokines, and growth factors. In addition to its traditional synaptic functions, the brain produces a vast array of peptide hormones, and this has led to the discipline of neuroendocrinology. Through the production of hypothalamic releasing factors, the central nervous system (CNS) exerts a major regulatory influence over

pituitary hormone secretion (Chap. 390). The peripheral nervous system stimulates the adrenal medulla. The immune and endocrine systems are also intimately intertwined. The adrenal hormone cortisol is a powerful immunosuppressant. Cytokines and interleukins (ILs) have profound effects on the functions of the pituitary, adrenal, thyroid, and gonads. Common endocrine diseases such as autoimmune thyroid disease and type 1 diabetes mellitus are caused by dysregulation of immune surveillance and tolerance. Less common diseases such as polyglandular failure, Addison's disease, and lymphocytic hypophysitis also have an immunologic basis. Immune therapies for cancer and various autoimmune diseases can initiate autoimmune endocrine disease as a side effect of treatment. The interdigitation of endocrinology with physiologic processes in other specialties sometimes blurs the role of hormones. For example, hormones play an important role in maintenance of blood pressure,

Endocrinology and Metabolism PART 12 intravascular volume, and peripheral resistance in the cardiovascular system. Vasoactive substances such as catecholamines, angiotensin II, endothelin, and nitric oxide are involved in dynamic changes of vascular tone in addition to their multiple roles in other tissues. The heart is the principal source of atrial natriuretic peptide, which acts in classic endocrine fashion to induce natriuresis at a distant target organ (the kidney). Erythropoietin, a traditional circulating hormone, is made in the kidney and stimulates erythropoiesis in bone marrow (Chap. 66). The kidney is also integrally involved in the renin-angiotensin axis (Chap. 398) and is a primary target of several hormones, including parathyroid hormone (PTH), mineralocorticoids, fibroblast growth factor 23 (FGF23), and vasopressin. The GI tract produces a vast array of peptide hormones, such as glucagon-like peptide 1 (GLP1), cholecystokinin, ghrelin, gastrin, secretin, and vasoactive intestinal peptide, among many others. Carcinoid and islet tumors can secrete excessive amounts of these hormones, leading to specific clinical syndromes (Chap. 89). Many of these GI hormones are also produced in the CNS, where their functions are poorly understood. Adipose tissue produces leptin, which acts centrally to control appetite, along with adiponectin, resistin, and other hormones that regulate metabolism. As hormones such as inhibin, ghrelin, and leptin are discovered, they become integrated into the science and practice of medicine on the basis of their functional roles rather than their tissues of origin. Characterization of hormone receptors frequently reveals unexpected relationships to factors in nonendocrine disciplines. The growth hormone (GH) and leptin receptors, for example, are members of the cytokine receptor family. The G protein-coupled receptors (GPCRs), which mediate the actions of many peptide hormones, are used in numerous physiologic processes, including vision, smell, and neurotransmission. PATHOLOGIC MECHANISMS OF ENDOCRINE DISEASE Endocrine diseases can be divided into three major types of conditions: (1) hormone excess, (2) hormone deficiency, and (3) hormone resistance (Table 388-1). ■ ■ CAUSES OF HORMONE EXCESS Syndromes of hormone excess can be caused by neoplastic growth of endocrine cells, autoimmune disorders, and excess hormone administration. Benign endocrine tumors, including parathyroid, pituitary, and adrenal adenomas, often retain the capacity to produce hormones, reflecting the fact that these tumors are relatively well differentiated. Many endocrine tumors exhibit subtle defects in their "set points" for feedback regulation. For example, in Cushing's disease, impaired feedback inhibition of adrenocorticotrophic hormone (ACTH) secretion is associated with autonomous function. However, the tumor cells are less sensitive to feedback inhibition, as evidenced by ACTH suppression at higher doses of dexamethasone (e.g., high-dose dexamethasone test) (Chap. 398). Similar set point defects are also typical of parathyroid adenomas and autonomously functioning thyroid nodules. The molecular basis of some endocrine tumors, such as the multiple endocrine neoplasia (MEN) syndromes (MEN1, 2A, 2B), has provided important insights into tumorigenesis (Chap. 402).

MEN1 is characterized primarily by the triad of parathyroid, pancreatic islet, and pituitary tumors. MEN2 predisposes to medullary thyroid carcinoma, pheochromocytoma, and hyperparathyroidism. The MEN1 gene, located on chromosome 11q13, encodes a tumor-suppressor gene, menin. Analogous to the paradigm first described for retinoblastoma, the affected individual inherits a mutant copy of the MEN1 gene, and tumorigenesis ensues after a somatic “second hit” leads to loss of function of the normal MEN1 gene (through deletion or point mutations). In contrast to inactivation of a tumor-suppressor gene, as occurs in MEN1 and most other inherited cancer syndromes, MEN2 is caused by activating mutations in a single allele. In this case, activating mutations of the RET protooncogene, which encodes a receptor tyrosine kinase,

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