	Thin skin	
	HYPER-	HYPO-
Diagnosis	1. Establish cortisol excess Overnight dex-meth suppression test -> Cushings = no cortisol suppression 24hr free urinary cortisol IF ABNORMAL 48hr dex-meth suppression test -> Cushings = failure to suppress cortisol 2. Establish source of cortisol excess Plasma ACTH CRH suppression test CT pituitary Petrosal sinus sampling (gradient >3 = pituitary driven)	
Management	Treat underlying cause Surgery Radiotherapy	
Complications	CV mortality Osteoporosis Hypertension	
Aldosterone		
Description	Production od aldosterone independent of RAAS, causing increased Na+ and water retention	
Aetiology	Aldosterone producing adenoma (Conns syndrome) Bilateral adrenocortical hyperplasia Adrenal Carcinoma	
Presentation	Hypokalaemia Weakness Cramps Paraesthesia Polyuria Polydipsia Hypertension	
Diagnosis	Bloods: U+E Renin/aldosterone ratio CT/MRI adrenals	
Management	Laproscopic adrenalectomy -4 weeks pre-op spironolactone (BP and K+ control) Spironalactone	
Catecholamine - PHAEOCHROMOCYTOMA		
Aetiology	Catecholamine producing tumour of chromaffin cells in adrenal medulla. Follow the 10% rule: • 10% malignant • 10% extra-adrenal • 10% bilateral • 10% familial Associated with MEN2a-2b	
Presentation	Classic Triad: 1. Episodic headache 2. Sweating 3. Tachycardia Hypertension	
Diagnosis	Bloods: FBC Plasma catecholamines 24hr free urinary catecholamines Clonidine suppression test	