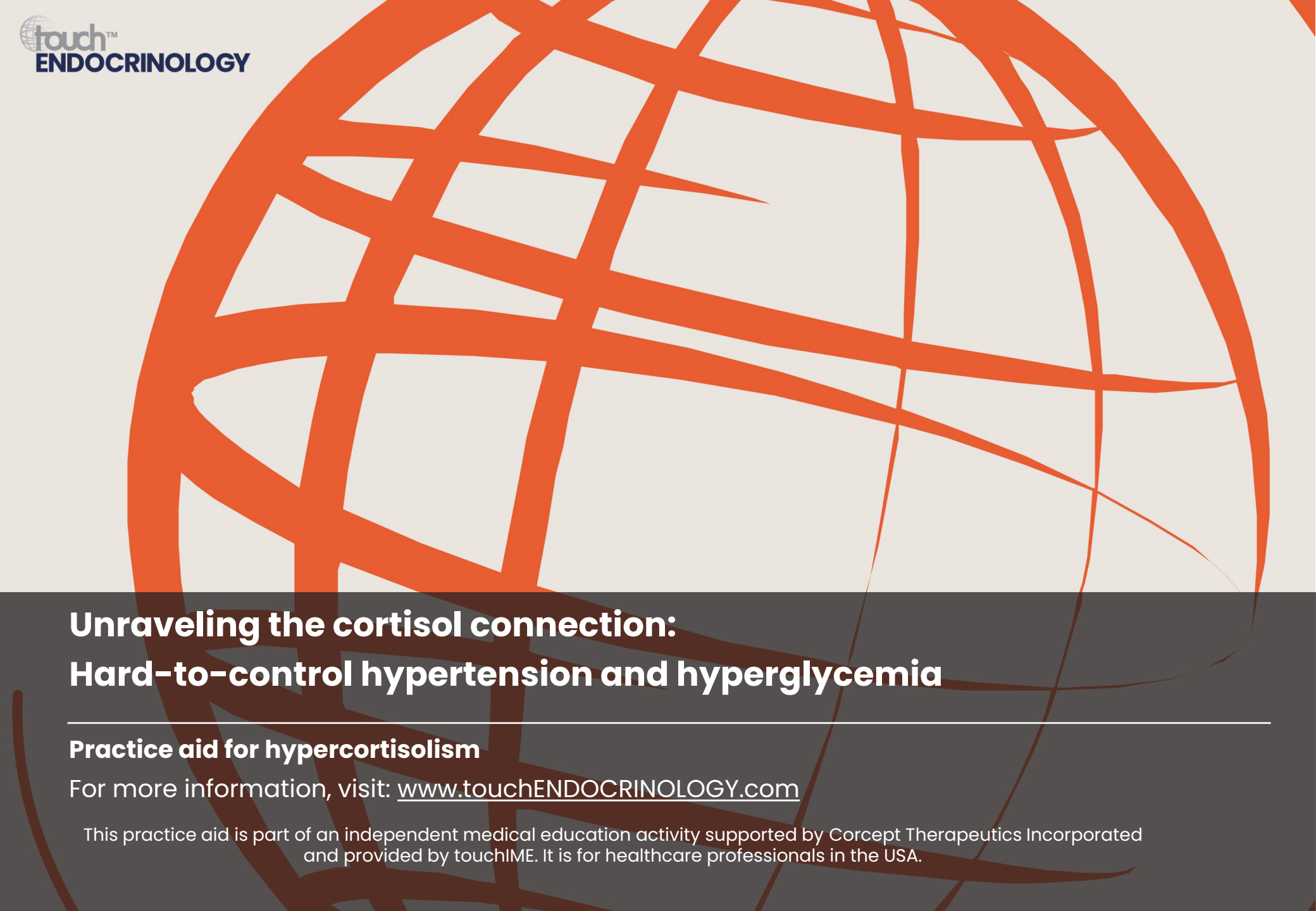


A large, stylized orange grid pattern, resembling a globe or a wireframe sphere, is overlaid on the entire page. The grid lines are thick and intersect to form a series of squares and rectangles of varying sizes.

Unraveling the cortisol connection: Hard-to-control hypertension and hyperglycemia

Practice aid for hypercortisolism

For more information, visit: www.touchENDOCRINOLOGY.com

This practice aid is part of an independent medical education activity supported by Corcept Therapeutics Incorporated and provided by touchIME. It is for healthcare professionals in the USA.

At-risk populations who should be screened for hypercortisolism¹⁻⁷

Aside from patients with features suggestive of overt Cushing's syndrome,* the following patients should be screened for possible hidden hypercortisolism:



Hypertensive patients with specific characteristics, e.g.

- Sudden worsening
- Treatment-resistant disease
- Non-dipping BP profile
- Extensive BP-related organ damage



Patients with difficult-to-control or suddenly worsening diabetes, e.g.

- T2D with HbA1c >7.5% despite multiple medications
- T2D with high insulin dose requirements, especially prandial insulin



Patients with unexplained bone disease or fragility fractures, e.g.

- Very low or rapidly declining bone density, not responding to osteoporosis treatment
- History of vertebral fracture, especially in obese patients



Patients with unusual features for their age, e.g.

- Hypertension onset before age 30
- T2D onset before age 40
- Premenopausal women with fragility fracture



Patients with multiple and unexplained or progressive features, e.g.

- Patients with T2D and hypertension, requiring ≥2 drugs to control BP
- Patients with T2D and hypertension, requiring insulin to control blood sugar



Patients with adrenal incidentaloma, i.e.

- Patients with adrenal mass detected on imaging for reasons other than suspected adrenal disease

*E.g. Easy bruising, facial plethora, proximal myopathy or muscle weakness, or striae (reddish-purple and >1 cm wide, non-blanching).

Primary care process for screening, workup, and referral for hypercortisolism⁴

Screen for hypercortisolism based on clinical suspicion

Hypercortisolism is more prevalent in specific at-risk populations

01

Perform biochemical testing

Overnight 1-mg DST should be used as the most sensitive first-line test

03

Refer to an endocrinologist

Provide all necessary information including medical history, clinical findings and test results, plus reasons for suspecting hypercortisolism

05

02

Take holistic patient history

Consider medications, physical exam, comorbidities, lab results

04

Interpret results

Abnormal DST results:
≥1.8 µg/dL serum cortisol with
>140 ng/dL dexamethasone;
Consider results within the context of the patient’s history and presentation

Abbreviations and references

Abbreviations

BP, blood pressure; DST, dexamethasone suppression test; HbA1c, glycated hemoglobin; T2D, type 2 diabetes.

References

1. Nieman LK, et al. *J Clin Endocrinol Metab.* 2008;93:1526–40.
2. Fallo F, et al. *J Hypertens.* 2022;40:2085–101.
3. Giovanelli L, et al. *J Endocrinol Invest.* 2021;44:1581–96.
4. Kushner P, et al. *Fed Pract.* 2024;41(Suppl. 6):S23–8.
5. Samson SL. *Endocr Pract.* 2026;32:473–518.
6. Buse JB, et al. *Diabetes Care.* 2025;48:2012–20.
7. Fassnacht M, et al. *Eur J Endocrinol.* 2023;189:G1–42.

The guidance provided by this practice aid is not intended to directly influence patient care. Clinicians should always evaluate their patients' conditions and potential contraindications and review any relevant manufacturer product information or recommendations of other authorities prior to consideration of procedures, medications, or other courses of diagnosis or therapy included here.

Our practice aid coverage does not constitute implied endorsement of any product(s) or use(s). touchENDOCRINOLOGY cannot guarantee the accuracy, adequacy or completeness of any information, and cannot be held responsible for any errors or omissions.