ENDO 2023

**Hyperaldosteronism**

* Use of steroid profiling – may be useful to distinguish bilateral from unilateral adenoma/hyperplasia
* PA genotypes display differences in histology, steroidogenic enzyme expression & aldo-regulated gene expression

**Abnormalities of water balance**

* Hypokalaemia not usually seen in SIADH – suggests solute depletion – eg alcoholism, beer potomania
* Stabilise Na+ level by matching urine output with dextrose
* Osmotic demyelination usually occurs if Na+ <120mmol/L
* Correction 10-12 safe, high risk, use 8
* Greatest risk in hypovolaemic pts treated with volume repletion (NS or 3% Na)
* Langerhan’s histiocytosis: DI usually first feature – need to follow up + imaging
* Start Desmopressin at night
* Ask pt to delay dose once weekly until aquaresis occurs, inform symptoms hypoNa
* Use 24hr urine as estimate of daily intake. Include insensible losses - ~800ml/day
* Na+ 130-134 usually not associated with complications – may be higher in elderly
* Consider DEXA
* Hypertonic Na test requires 30m turnaround Na from lab
* Chronic primary polydipsia - lose urinary concentrating ability 400-600mOsmol/kg. Normal >800
* 3-5 days to restore normal concentrating ability

**NAFLD**

* CV disease leading cause of death
  + Bariatric surgery: NASH resolution 1yr
* Semaglutide: dose-dependent resolution NASH 5% body wt loss. Not sustained (improvement in placebo)
* Pioglitazone: Improvement in liver histology, resolution NASH (58%), prevention fibrosis in trials
* Combination pioglitazone/exenatide/metformin: 3yr study - EDICT n=68- Steatosis, fibrosis significantly reduced

**Phaeochromocytoma**

* Metanephrines, 3MT best, catecholamines obsolete
* Plasma vs urine: Sensitivity slightly better for plasma, specificity similar
* All potentially metastatic - usually years after successful resection - can recur after 25-30y. Not “benign”
* Adrenaline - episodically released - alpha 1 beta 1, 2
* Noradrenaline - continuously released, high affinity alpha 1, beta 1, a1 vasoconstriction, hypertension
* Does not present as hypertension alone. Don’t investigate if no symptoms/signs
* Optimal adrenoreceptor blocker should be given 7-14d prior to surgery; high Na+ diet to prevent hypotension
* Phenoxybenzamine worsens tachycardia
* Ivabradine - useful in catecholamine-induced. Acts on SA node exclusively

**Aldosterone**

Types of PA - 60% bilateral PA, 10% asymmetric bilateral hyper-aldo

Proposed continuum of adrenal pathology - expansion of aldo-producing micronodules

**Low-risk thyroid cancer**

Thyroglobulin:

<0.2 ng/ml – excellent prognosis

<1 – indeterminate

>1 – incomplete biochemical response

Can measure with mass spec if necessary

Ultrasound

False positive 67%

Right level 4, 3, 2 recurrence sites

Annual – standard advice

When to end follow-up (survey of practice)

Majority >20y – often 6-10y

Reduce frequency of US at 5y

Low risk, no recurrence – 6/12 -> 1y, 5y before discharge

TSH suppression

Useful if high risk

Target lower end of range (eg. 2)

Benefit less certain for low risk patients

**TRAVERSE Trial – testosterone supplementation**

Subjects: 45-80y, >= 1 symptoms hypogonadism, CVD or >= risk factors

316 sites

Dose titrated to 12-16, Hct <= 0.54

CVD: HR 0.96 – satisfied non-inferiority

Prostate: no difference: high-grade or any Ca, BPH intervention, retention, LUT symptoms

Anaemia – greater correction in T group compared to placebo

Glycaemia – no difference

Hypogonadal symptoms – improved

Fracture – increased. Unexpected outcome. Most associated with trauma. No difference atraumatic