**Unilateral non-functional adrenal adenoma with imaging features consistent with a benign lesion**

**Letter to Primary Care Provider**

\_\_\_\_\_\_\_\_\_ is being discharged from the endocrine clinic.

Rationale for discharge from Endocrine Care:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has an adrenal lesion with benign imaging findings. Adrenal incidentalomas are common, affecting ~2% of the general population and >7% of those over age 70. Repeat imaging of the adrenal glands at 1 year has shown stability with consistent demonstration of benign features. Biochemical testing has demonstrated no concerns for hormonal hypersecretion in this patient.

Summary of key results:

**Blood work:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Pheochromocytoma Screening** | **Cushing’s Syndrome Screening** | **Hyperaldosteronism Screening** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Imaging:**

Baseline CT or MRI adrenals (mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Follow-up CT or MRI adrenals at 6-12 months (mm/yy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surveillance:

At this point in time there is no need for routine repeat imaging or hormonal biochemical testing. After an initial normal 1mg dexamethasone suppression test, overt cortisol hypersecretion is very uncommon (< 0.1%); therefore, routine serial screening is not required. Further testing should be carried out if symptoms or signs of cortisol excess (Cushing’s) were to develop.

Criteria for escalation or re-referral:

Please refer back to myself or another endocrinologist if there is:

1. New or worsening diabetes (especially with rapid progression), resistant hypertension (requiring multiple medications or is difficult to control), fragility fractures/osteoporosis, or unexplained hypokalemia
2. Other clinical concerns for Cushing’s syndrome, hyperaldosteronism, pheochromocytoma, or androgen excess