
# DISORDINI PSICOSOCIALI: IMPATTO DELL'IMMAGINE CORPOREA


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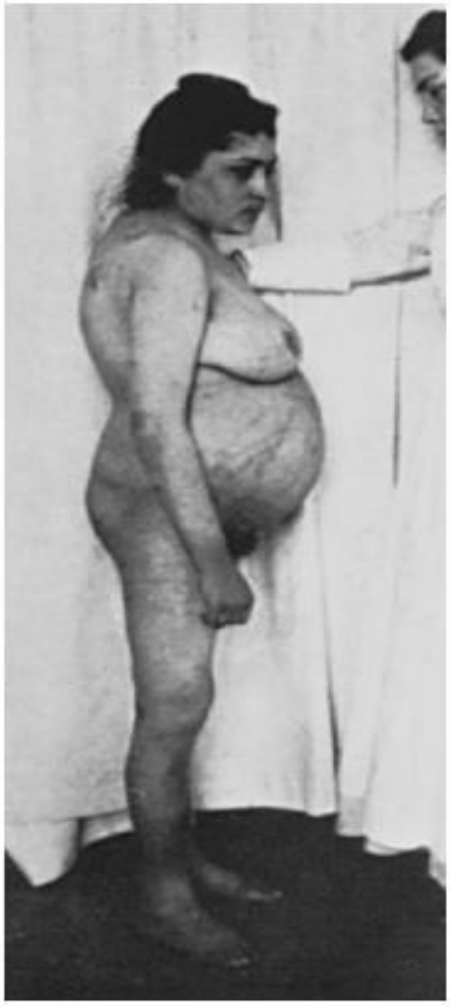
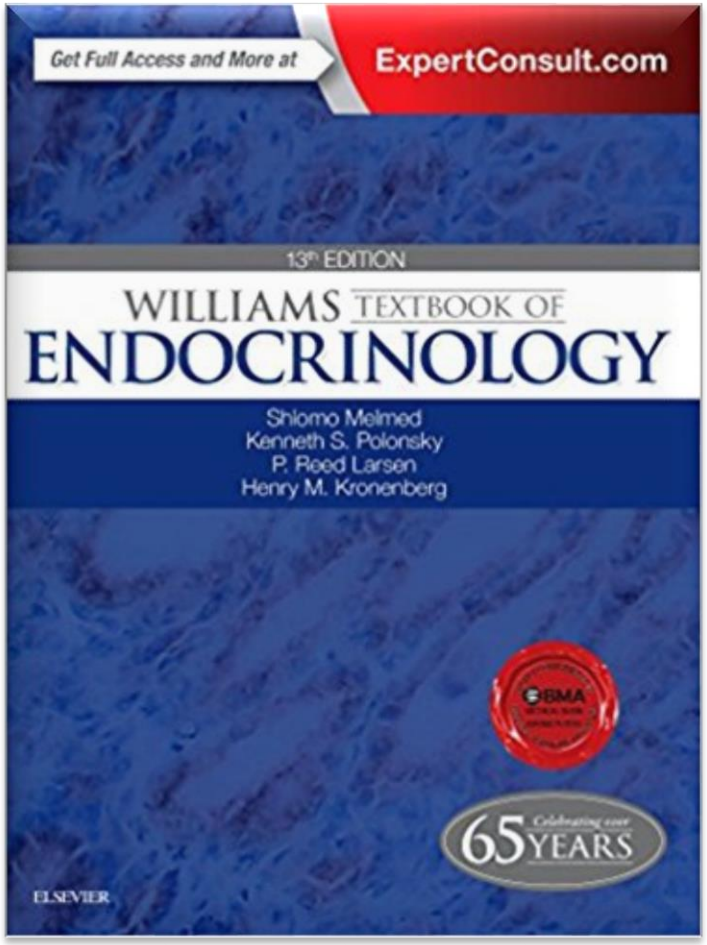
# Il fenotipo con sindrome di Cushing e l'immagine di Sé



**Nel 1912, Harvey Cushing è stato il primo a descrivere una donna di 23 anni con obesità, amenorrea, irsutismo, faccia a forma di luna.**

# Comorbidità




## Psychiatric Features

Psychiatric abnormalities occur in approximately 50% of patients with Cushing syndrome, regardless of cause.[181,182] Agitated depression and lethargy are among the most common problems, but paranoia and overt psychosis are also well recognized. Memory and cognitive function may also be affected, and increased irritability may be an early feature. Insomnia is common, and both rapid eye movement and delta-wave sleep patterns are reduced.[183] Lowering of plasma cortisol by medical or surgical therapy usually results in a rapid improvement in the psychiatric state. Overall quality of life is significantly reduced in patients with Cushing syndrome, particularly affecting physical health and functioning. Quality-of-life scores improve after treatment but do not return to normal.[184]

## Reproductive Organs

Gonadal dysfunction is common, with menstrual irregularity in females and loss of libido in both sexes. Hirsutism is frequently found in female patients, as is acne. The most common form of hirsutism is vellus hypertrichosis on the face; this type should be distinguished from the darker, terminal differentiated hirsutism that may occur because of ACTH-mediated adrenal androgen excess. Hypogonadotropic hypogonadism occurs because of a direct inhibitory effect of cortisol on GnRH pulsatility and LH/FSH secretion, and it is reversible on correction of the hypercortisolism.[179,180]

# Qualità della vita e sindrome di Cushing

Pituitary (2015) 18:195–200
DOI 10.1007/s11102-015-0640-y

## Quality of life in Cushing's syndrome

**Alicia Santos · Iris Crespo · Anna Aulinas · Eugenia Resmini · Elena Valassi · Susan M. Webb**

Published online: 3 February 2015


**Abstract**
*Introduction* Cushing syndrome (CS) of any etiology (adrenal, pituitary or ectopic) impacts negatively on health-related quality of life (QoL), especially in active hypercortisolism but also after endocrine cure. Both generic questionnaires like the short-form 36 health survey -SF-36- and the derived SF-12, or the Hospital Anxiety and Depression Scale (HADS), and disease-specific measures like the CushingQoL and the Tuebingen CD-25 questionnaires have provided information on the impact of CS on patients perceived health.
*Materials and methods* Studies published since January 2013 until November 2014 on QoL in patients with CS were identified, reviewed and summarized.
*Conclusions* Treatment of CS improves patients perceived QoL, but it often takes many months and often never normalizes. In parallel to persistent QoL impairment in cured CS, brain and cerebellar volume are reduced. Depression, anxiety and cognitive dysfunction are common. Pediatric patients with CS also present worse QoL than normal children, as well as additional issues like delayed growth and pubertal development, next to abnormal body composition, psychological and cognitive maturation. Fluoxetine has been suggested as a neuroprotectant and antidepressant for patients with CS, although no prospective studies are yet available. The CushingQoL questionnaire has been mapped to well-validated instruments like SF-36 or EQ-5D, and therefore may be used in cost-utility and other health economy studies.

**Keywords** Quality of life · Cushing syndrome · Therapy for Cushing syndrome

### Introduction

In the last decade it has become evident that suffering Cushing's syndrome (CS) negatively impacts on both physical and psychological dimensions, and therefore on affected patients' health-related quality of life (QoL), even after endocrine "cure" [1–3]. This evidence was initially

# Diagnosi precoce e Qualità della vita

Endocr Pract. 2016 Jan;22(1):51-67. doi: 10.4158/EP15855.OR. Epub 2015 Oct 5.

## PATIENTS' PERCEPTION ON CLINICAL OUTCOME AND QUALITY OF LIFE AFTER A DIAGNOSIS OF CUSHING SYNDROME.

Papoian V, Biller BM, Webb SM, Campbell KK, Hodin RA, Phitayakorn R.

**Abstract**

**OBJECTIVE:** Excess cortisol production (Cushing syndrome, CS) is a chronic disease affecting many organ systems and impacting quality of life (QoL). This study analyzed factors associated with self-reported QoL, including aspects related to the diagnosis and treatment modalities of CS.

**METHODS:** In collaboration with the Cushing's Support and Research Foundation (CSRF), surveys using a validated QoL instrument were sent to CSRF members. Data were analyzed for associations between QoL and demographic, treatment, and disease factors.

**RESULTS:** A total of 269 patients completed the survey. Respondents were 89.9% female, and the mean age was 48 years (SD 12, range 16-76). Respondents visited a median of 4 physicians (range 1-40) prior to the diagnosis of CS, with a median of 5 years (mean 7, SD 5, range 1-30) to obtain a diagnosis, showing a statistically significant negative correlation (P<.001). In one-quarter of cases, someone other than a physician suggested the diagnosis. Multiple regression analysis demonstrated that remission status, time to diagnosis, radiation therapy, and hypopituitarism were significant predictors of QoL. There was no association between QoL and patient's sex, age, replacement steroid use, having follow-up with an endocrinologist, or surgical approach.

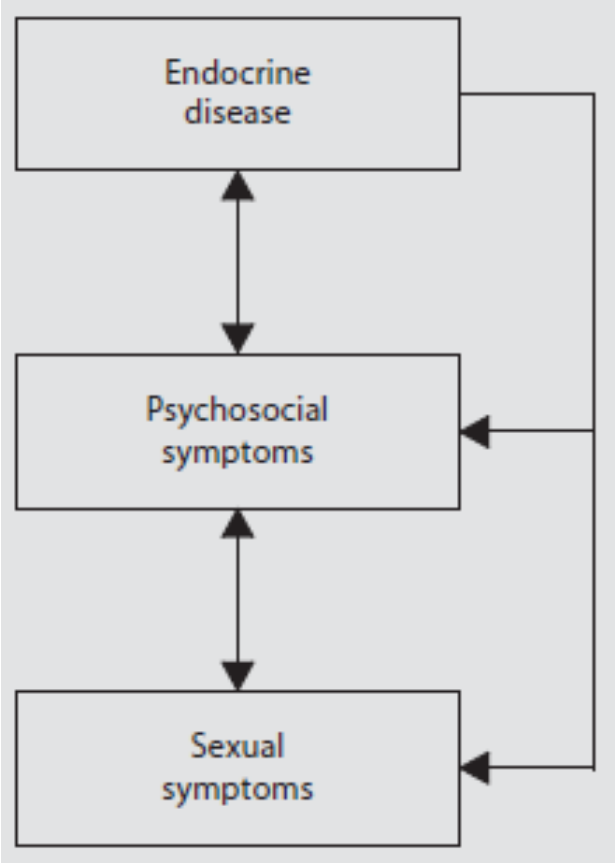
**CONCLUSION:** This is one of the largest QoL studies of CS patients and provides information for treatment and education goals. It is notable that early diagnosis and treatment was the major predictor of better QoL after achieving remission from disease, highlighting the need for awareness about the disorder. Patients in remission had better QoL, emphasizing the importance of disease control.

# Sexual Symptoms in Endocrine Diseases: Psychosomatic Perspectives

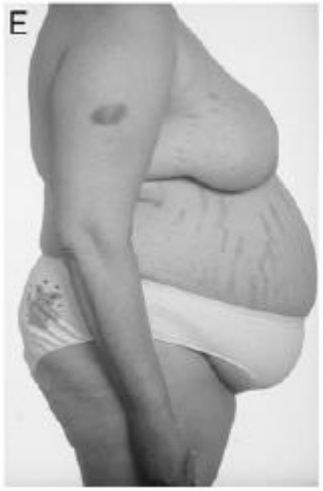
Giancarlo Balercia[a] Marco Boscaro[a] Francesco Lombardo[b] Eleonora Carosa[c]
Andrea Lenzi[b] Emmanuele A. Jannini[c]

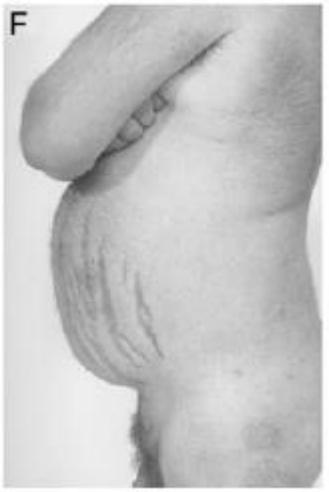
Psychother Psychosom 2007;76:134–140

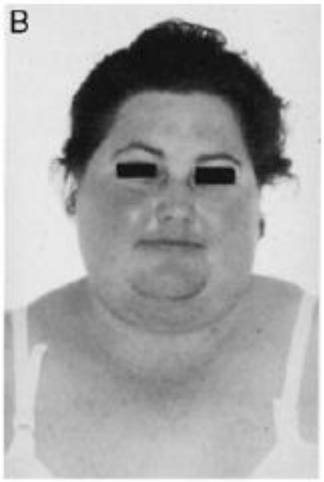
Il meccanismo di amplificazione del sintomo sessuale nelle malattie endocrine in grado di modificare la vita di relazione e l'immagine corporea è particolarmente efficiente nella M/S di Cushing

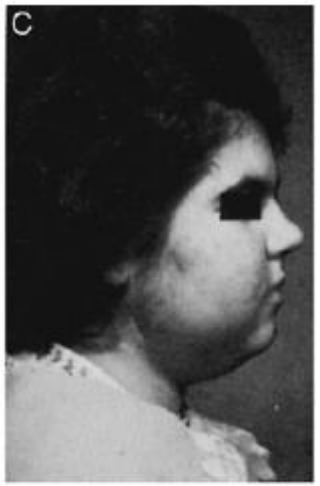


# Disagio per l'immagine corporea



# IMMAGINE CORPOREA: DALLA FISIOLOGIA ALLA PATOLOGIA

**L’ immagine corporea è l’immagine e l’apparenza del corpo umano che ci formiamo nella mente, e cioè il modo in cui il nostro corpo ci appare.**

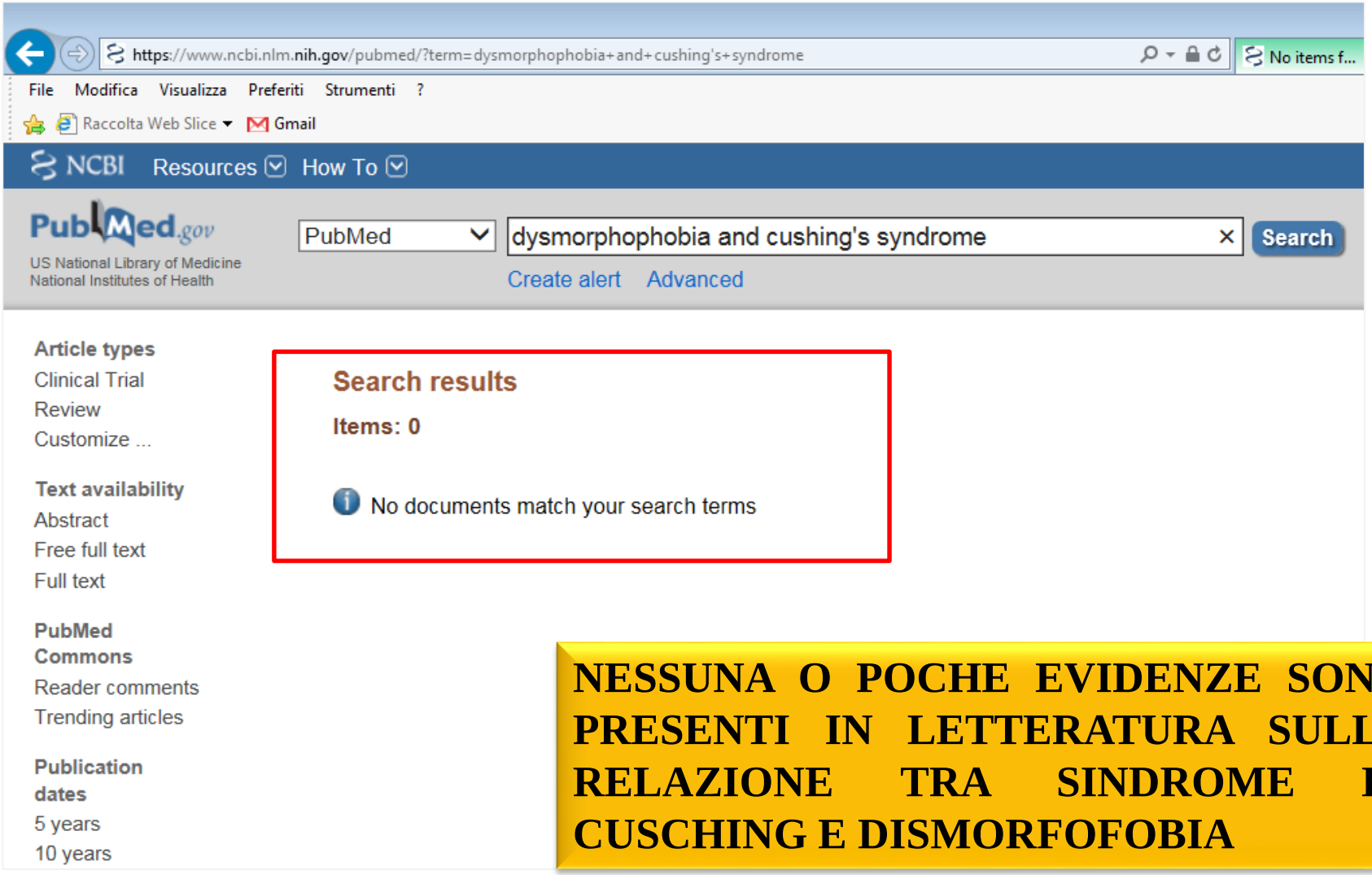

# DISTURBO DI DISMORFISMO CORPOREO

***Categorizzato tra disturbi ossessivo compulsivi***

***epidemiologia: 0,7% a 2,4%***

- Preoccupazione per uno o più difetti o imperfezioni percepiti nell'aspetto fisico che non sono osservabili o appaiono agli altri in modo lieve;
- A un certo punto, durante il decorso del disturbo l'individuo ha messo in atto comportamenti ripetitivi (ad esempio, guardarsi allo specchio; curarsi eccessivamente del proprio aspetto; stuzzicarsi la pelle, ricercare rassicurazioni) o azioni mentali (ad esempio, confrontare il proprio aspetto fisico con quello degli altri) in risposta a preoccupazioni legate all'aspetto.
- La preoccupazione causa disagio clinicamente significativo o compromissione del funzionamento in ambito sociale, lavorativo o in altre aree importanti;
- La preoccupazione legata all'aspetto non è meglio giustificata da preoccupazioni legate al grasso corporeo o al peso in un individuo i cui sintomi soddisfano i criteri diagnostici per un disturbo alimentare.

# DISMORFOFOBIA E CUSHING




**NESSUNA O POCHE EVIDENZE SONO PRESENTI IN LETTERATURA SULLA RELAZIONE TRA SINDROME DI CUSCHING E DISMORFOFOBIA**

Published in final edited form as:
*J Pediatr Endocrinol Metab*. 2008 August ; 21(8): 771–780.

# Body Image in Adolescents with Disorders of Steroidogenesis

**Cong Ning**[1], **Liza Green-Golan**[3], **Constantine A. Stratakis**[1], **Ellen Leschek**[4], **Ninet Sinaii**[3], **Elizabeth Schroth**[5], **Monique Ernst**[5], and **Deborah P. Merke**[2,3,*]

## Abstract

**Aim**—Little is known about body image in children with endocrine conditions. We evaluated body image in children with congenital adrenal hyperplasia (CAH), familial male precocious puberty (FMPP), and Cushing's syndrome (CS).

**Study design**—We compared 67 patients (41 CAH, 12 FMPP, 14 CS) age 8–18 years with 55 age-matched controls.

**Results**—Patients expressed more weight unhappiness than controls (females: $p < 0.001$; males: $p \sim 0.01$). This difference remained for females after adjusting for body mass index (BMI) ($p \sim 0.03$), but not for males ($p \sim 0.12$). Unhappiness with height and age of appearance was similar between groups. In female patients, higher BMI was a significant predictor of weight unhappiness ($p \sim 0.01$).

**Conclusion**—Adolescents with CAH, FMPP, and CS are at risk for negative body image regarding weight, but not height or age of appearance. Weight unhappiness is partially related to greater weight, but factors unrelated to physical findings seem to contribute to negative body image in female patients.

Vol. 11: 1-13, March 2006

ORIGINAL RESEARCH PAPER

# The Body Uneasiness Test (BUT): Development and validation of a new body image assessment scale

M. Cuzzolaro*, G. Vetrone**, G. Marano***, and P.E. Garfinkel****

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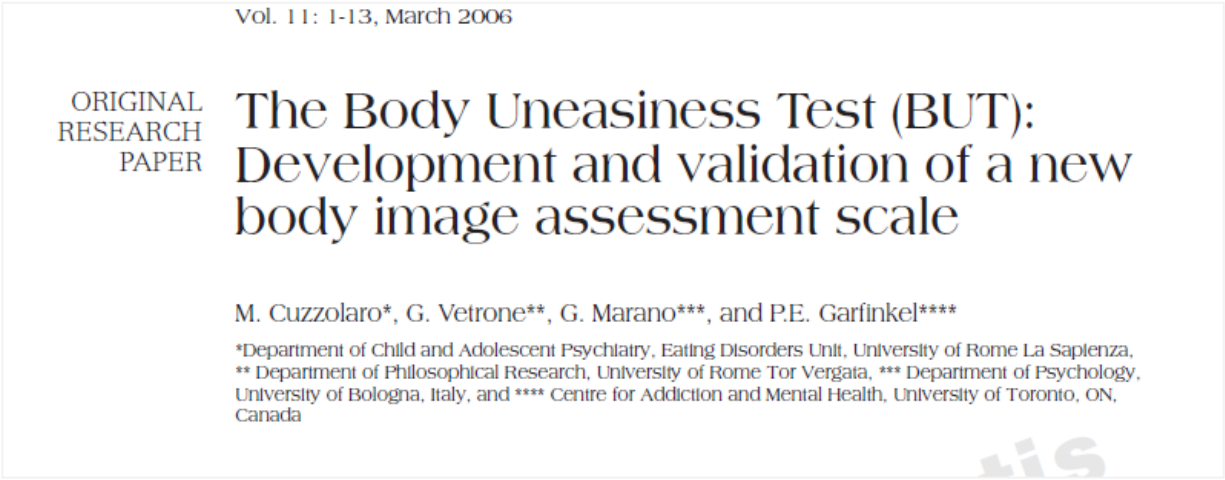
EATING AND WEIGHT DISORDERS: EWD · APRIL 2006

**TABLE 6**
Test-retest reliability.

| | Control subjects | ED subjects |
|---|---|---|
| **BUT A** | | |
| Global Severity Index | 0.91 | 0.90 |
| Weight phobia | 0.90 | 0.92 |
| Body image concerns | 0.89 | 0.88 |
| Avoidance | 0.71 | 0.83 |
| Compulsive self-monitoring | 0.73 | 0.80 |
| Depersonalization | 0.85 | 0.94 |

**TABLE 5**
Homogeneity and internal consistency.

| Subscale | Mean CITC | Cronbach |
|---|---|---|
| BUT•A Weight phobia | 0.71 | 0.84 |
| BUT•A Body image concern | 0.70 | 0.90 |
| BUT•A Avoidance | 0.63 | 0.79 |
| BUT•A Compulsive self-monitoring | 0.56 | 0.82 |
| BUT•A Depersonalization | 0.68 | 0.85 |
| BUT•B I | 0.70 | 0.88 |
| BUT•B II | 0.58 | 0.81 |
| BUT•B III | 0.65 | 0.84 |
| BUT•B IV | 0.55 | 0.75 |
| BUT•B V | 0.77 | 0.90 |
| BUT•B VI | 0.76 | 0.87 |
| BUT•B VII | 0.48 | 0.69 |
| BUT•B VIII | 0.58 | 0.77 |



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**EATING AND WEIGHT DISORDERS: EWD · APRIL 2006**

**Il BUT (Body Uneasiness Test, Cuzzolaro 1999) è composto da due sezioni.**

Nella prima sezione vengono valutati i seguenti aspetti o domini (subscales): fobia peso, preoccupazione per l'immagine corporea, evitamento, compulsione e ipercontrollo, depersonalizzazione, global severity index (GSI).

Nella seconda parte vi è una valutazione del disagio rispetto alle  diverse parti .

## BUT

Indichi con una X la risposta più vicina alla sua esperienza attuale

5= sempre; 4= molto spesso; 3=spesso; 2=qualche volta; 1= una volta; 0=raramente.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. Trascorro molto tempo davanti allo specchio. | 0 | 1 | 2 | 3 | 4 | 5 |
| 2. Non mi fido del mio aspetto: temo che cambi, all'improvviso. | 0 | 1 | 2 | 3 | 4 | 5 |
| 3. Mi piacciono gli abiti che nascondono le forme del mio corpo. | 0 | 1 | 2 | 3 | 4 | 5 |
| 4. Passo molto tempo pensando a certi difetti della mia immagine fisica | 0 | 1 | 2 | 3 | 4 | 5 |
| 5. Quando mi spoglio evito di guardarmi. | 0 | 1 | 2 | 3 | 4 | 5 |
| 6. Penso che la mia vita cambierebbe profondamente se potessi correggere alcuni miei difetti estetici. | 0 | 1 | 2 | 3 | 4 | 5 |
| 7. Mangiare in presenza di altri mi provoca ansia. | | | | | | |
| 8. Il pensiero di alcuni difetti del mio corpo mi torme impedirmi di stare con gli altri. | | | | | | |
| 9. Ho il terrore di ingrassare. | | | | | | |
| 10. Faccio lunghi confronti fra il mio aspetto e quello d | | | | | | |

**SELF-REPORT**

**34 ITEMS**

**SCALA LIKERT A 6 PUNTI**

**Indichi con una X la risposta più vicina alla sua esperienza attuale del mio corpo detesto:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | la statura | 0 | 1 | 2 | 3 | 4 | 5 |
| 2 | la forma della testa | 0 | 1 | 2 | 3 | 4 | 5 |
| 3 | la forma del viso | 0 | 1 | 2 | 3 | 4 | 5 |
| 4 | la pelle | 0 | 1 | 2 | 3 | 4 | 5 |
| 5 | i capelli | 0 | 1 | 2 | 3 | 4 | 5 |
| 6 | la fronte | 0 | 1 | 2 | 3 | 4 | 5 |
| 7 | le sopracciglia | 0 | 1 | 2 | 3 | 4 | 5 |
| 8 | gli occhi | 0 | 1 | 2 | 3 | 4 | 5 |
| 9 | il naso | 0 | 1 | 2 | 3 | 4 | 5 |
| 10 | le labra | 0 | 1 | 2 | 3 | 4 | 5 |
| 11 | la bocca | | | | | | |
| 12 | i denti | | | | | | |
| 13 | le orecchie | | | | | | |
| 14 | il collo | | | | | | |
| 15 | il mento | | | | | | |
| 16 | i baffi | | | | | | |

**BUT –II parte**
**37 ITEMS**

**SCALA LIKERT A 6 PUNTI**

# PROSPETTIVE FUTURE E IMMAGINE CORPOREA

**ASSESSMENT PSICOMETRICO PER UN TRATTAMENTO CENTRATO SULLA PERSONA**

**SUPPORTANDO IL DISCONFORT PSICOLOGICO LEGATO ALLA PROPRIA IMMAGINE CORPOREA**

**VALORIZZANDO LE RISORSE INDIVIDUALI E L'ALLEANZA TERAPEUTICA**

# GRAZIE !!!

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