Cushing’s syndrome (CS) is rare during pregnancy because anovulation, particularly in the ACTH-dependent Cushing’s disease, adds to an already infrequent process (5-25 cases per million/year). Most of the sparse published cases are due to adrenocortical tumors. Hypercortisolism has been attributed responsibility in maternal complications, including hypertension, (2 out of 3 mothers), diabetes (25%), and even death in (2%). The related fetal adversities list preterm labor (60%), intrauterine growth restriction (26%), and other complications, including perinatal death in 15%. The low incidence of CS has impaired the release of management guidelines. Recently, advances in laparoscopy, have added to inhibitors of steroidogenic enzymes and to surveillance as alternatives for management. So, dilemma challenges clinicians facing CS is whether use medical treatment, surgery (open or laparocopy), or both of them. These caveats are analyzed taking as a basis the following case. A 21-year old pregnant woman was referred to our centre at the 25th week because of several clinical traits of hypercortisolism. Hypercortisolism (urinary free cortisol 1200 µg/24 h), undetectable ACTH, mild anemia, hypokalemia, and gestational diabetes were consistent with CS. The ACTH-independent hypercortisolism impelled investigation of the adrenal gland. A left, 45 mm mass isolated was detected with magnetic resonance. The following days added pneumonia and severe preeclampsia as further complications, so we added metyrapona. Finally Laparoscopic excision (agreeing with endocrinologist and surgeons) at the 29th week confirmed an adrenal adenoma (Figure 1). Replacement with oral glucocorticoids was then initiated. One week after discharge, the patient returned with preterm labor. Tocolysis stopped labor and, within days, hypertension and proteinuria diappeared. The course was uneventful until premature rupture of membranes at the 33rd week, and the subsequent vaginal delivery of a healthy 2270 g male. Replacement with glucocorticoids was maintained for 15 additional months. The exceptionality of CS during pregnancy creates uncertainties about the appropriate management.