RESULTS

A man suffered from daily headache, nausea, lethargy, loss of weight and blurred vision for one year. He was thirsty all the time and drank eight liters of fluid in a day with bothersome nocturia. He was intolerant of cold weather and had constipation and noticed dry skin. His libido was low. His progressive reduction in effort tolerance resulted in him unable to continue working. On examination, he was of medium built with bradycardia and dry skin. Visual confrontation revealed bitemporal hemianopia. Laboratory investigations revealed central hypothyroidism, hypogonadotropic hypogonadism, central hypocortisolism and a compensated cranial diabetes insipidus. Imaging revealed a heterogeneously enhancing mass in the sella measuring 19 x 12 x 12 mm with suprasellar extension causing mass effect into the optic chiasm. The pituitary stalk was not visualized. Hormonal replacement was commenced. He underwent trans-sphenoidal surgery and histopathology showed chronic hypophysitis. He was then pulsed with steroid and had clinical improvement.

CONCLUSION

Differentiating autoimmune hypophysitis from non-secreting pituitary adenoma before surgery would greatly benefit the patient. It avoids the possible complications of surgery. Furthermore, autoimmune hypophysitis can be successfully treated with medications. Another important learning point from this case is to highly suspect hypophysitis in a patient who has cranial diabetes insipidus even before any pituitary surgery.

PP-23

EMPTY SELLA SYNDROME WITH ECTOPIC GROWTH HORMONE SECRETION – AN UNUSUAL PRESENTATION OF ACROMEGALY

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INTRODUCTION

Empty sella syndrome is a radiological diagnosis characterised either by primary of secondary causes. Individuals with empty sella syndrome do not have any associated symptoms, but some may exhibit features suggestive of hypopituitarism. We report a case of a female with symptoms of florid growth hormone excess with radiological evidence of empty sella syndrome.

RESULTS

A 59-year-old Malay female was initially referred for poorly controlled diabetes with HBA1c of 12.5% requiring very high doses of insulin. On further history, she claimed that her ring size increased from size 20 at the time she got married to size 25 along with increased shoe size from 7 to size 10 in a span of 6 years. On clinical examination, she had typical features of acromegaly. Formal Bjerrum testing showed normal visual fields. IGF-1 level was elevated at 655ug/L (97-292). Her other anterior pituitary hormonal tests were normal. Her growth hormone (GH) was not suppressed following an oral glucose load (OGTT). Brain MRI revealed non-visualisation of normal pituitary gland with CSF filled sella turcica suggestive of empty sella syndrome. A contrast-enhanced computed tomography revealed a soft tissue density seen at the right lateral aspect of the pituitary fossa which is most likely arising from the sella turcica. She was then referred to neurosurgery.

CONCLUSION

We described a patient with clinically and biochemically proven acromegaly with an empty sella syndrome on MRI. Early screening and detection would be imperative for earlier neurosurgical referral for better outcome.

PP-24

APOPLECTIC CORTICOTROPIN-PRODUCING MACROADENOMA: A RARE ENTITY

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INTRODUCTION

Pituitary tumour apoplexy is defined as infarction, haemorrhage or combination of both occurring in a pituitary tumour as a result of expansion of the tumour causing altered sensorium, visual and ophthalmic disturbances and hormonal deficiencies. It is uncommon and mostly happens in macroadenomas. The prevalence of apoplexy is extremely rare in corticotropin-producing adenoma.