CR-GE-35

SUBCLINICAL SECONDARY ADRENAL INSUFFICIENCY IN A PATIENT WITH MALNUTRITION – INTERRELATIONSHIP OF NUTRITION AND ENDOCRINOLOGY

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INTRODUCTION

The syndrome of protein-calorie malnutrition (PCM) entails not only nutritional deficiencies, but also affects the levels of various hormones. Some vulnerable patients might have maladaptive responses and could lead to clinical catastrophic outcomes if left undetected.

CASE

A 41-year-old Thai man with underlying major depression presented with weight loss and nonhealing ulcer at the left heel for 3 months. Nutrition-focused physical examinations were consistent with severe PCM and multiple micronutrient deficiencies especially zinc deficiency. He was hospitalized and treated with combined enteral and parental nutrition. During admission, morning cortisols were done as a part of investigations. The cortisol results were unexpectedly low at the level of 3.7-4.7 μg/dL. The patient failed to respond to a 250 μg ACTH stimulation test (peak cortisol at 17 μg/dL) and plasma ACTH showed normal level. Other pituitary hormones were normal. MRI pituitary gland showed only a microadenoma 5 mm at left lobe of pituitary gland. Oral prednisolone was given and continued for 3 months after discharge. Subsequent ACTH test at OPD showed reversible adrenal insufficiency and prednisolone was tapered off. The patient gradually recovered from malnutrition and mental illness.

CONCLUSION

Endocrine changes due to malnutrition are part of an adaptive mechanism. Most malnourished patients have normal or high cortisol levels; however, some patients might have adrenal insufficiency from maladaptive responses to stress. Early detection and management of adrenal insufficiency should be addressed in these patients.

KEY WORDS

subclinical secondary adrenal insufficiency, malnutrition, interrelationship

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HIDDEN IN PLAIN SIGHT: PITUITARY APOPLEXY IN A PATIENT PRESENTING WITH VISUAL LOSS AND CONJUNCTIVITIS

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INTRODUCTION

Apoplexy, a rare complication of pituitary tumors, may be the initial manifestation of a previously unknown pituitary pathology. It usually presents with headache, visual impairment or ophthalmoplegia which may be severe and of sudden-onset. Imaging will reveal a pituitary mass with hemorrhagic component.

CASE

A 72-year-old male was admitted due to headache and blurring of vision. He was hypertensive, with history of ischemic stroke (2014) and bilateral renal cell carcinoma post-nephrectomy of the left kidney (2008). One week prior, he was given an initial dose of Pazopanib, a kinase inhibitor used in advanced renal cell carcinomas. He developed headache, anorexia and weakness after 4 days. Blurring of vision with lid swelling and mucoid discharge occurred a day prior to admission. Assessment was bacterial conjunctivitis, hence he was started on antibiotic eye drops. Visual acuity was reduced to light perception in both eyes during this time. Due to headache persistence, cranial MRI was done to rule out metastasis or stroke. There was a 2.8x1.9x2.2 cm mass in the sellar region with heterogenous internal signal displacing the optic chiasm. Pituitary apoplexy was considered, and hormonal work-up revealed central adrenal insufficiency, central hypothyroidism and hypogonadotropic hypogonadism. Steroid replacement was initiated followed by thyroid hormone supplementation then transphenoidal endoscopic pituitary surgery. Histopathology confirmed pituitary adenoma with hemorrhage and necrosis. He was sent home improved on levothyroxine and prednisone.

CONCLUSION

Pituitary apoplexy is a rare endocrine emergency. It can be a diagnostic challenge, hence, a high index of suspicion should be exercised by clinicians.

KEY WORDS

pituitary apoplexy, hypopituitarism, pituitary tumor