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NEUROENDOCRINE TUMOR OF THE LUNGS SECONDARY TO DIFFUSE IDIOPATHIC PULMONARY NEUROENDOCRINE CELL HYPERPLASIA (DIPNECH)

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CASE

A 66-year-old female, known diabetic and hypertensive, with diagnosis of invasive ductal carcinoma of the right breast presented with a chest x-ray finding of a round lung density in the right paravertebral region at the level of T10-11. Chest CT scan showed multiple non-calcified nodules in the right middle and both lower lobes. CT guided biopsy of the dominant lung nodule was positive for Synaptophysin, Chromogranin, CD-56 with Ki-67 of 1-3%, compatible with Typical Carcinoid Tumor. Bone scan was negative. Video Assisted Thoracic Surgery (VATS) with wedge resection of the right lung and middle lobe confirmed the diagnosis of well differentiated pulmonary endocrine tumor, with nolymphovascular invasion. The background lung tissue from the right middle lobe revealed multiple foci of neuroendocrine tumor (0.1 cm to 0.4 cm); the right lower lobe tissue (0.1 cm to 0.3 cm) with areas of focal neuroendocrine cell hyperplasia. She was generally asymptomatic except for occasional cramps of the lower extremities, frequent watery stools with 4 kg weight loss and intermittent facial flushing. A multidisciplinary team confirmed the diagnosis of a rare case of lung carcinoid, non-functional, arising from Diffuse Idiopathic Pulmonary Neuroendocrine Cell Hyperplasia (DIPNECH). Consensus plan consisted of presevation of lung parenchyma and close follow-up. She underwent total right mastectomy and was maintained on Tamoxifen. No further surgery was planned at this time and she continues to be asymptomatic.

KEY WORDS

typical neureoendocrine tumor, diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (dipnech), tumorlets, immunohistochemical staining

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PRIMARY PARTIAL EMPTY SELLA PRESENTING WITH PREPUBERTAL HYPOGONADOTROPIC HYPOGONADISM: A CASE REPORT

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INTRODUCTION

This case report discusses the approach to diagnosis of a 20-year-old male presenting with micropenis with absent secondary sexual characteristics.

CASE

The patient has eunuchoid habitus, gynecomastia, and genital and pubic hair development of Tanner Stage 1. He has a flaccid and stretched penile lengths of 2.5 and 3 centimeters respectively, palpable small, firm left testis and undescended right testis. Neurologic examination was unremarkable except for anosmia. Cranial MRI with contrast is suggestive of partially empty sella. Chromosome analysis revealed a kayotype with no numerical and structural aberrations and an XY sex chromosome. He has delayed bone age using Greulich-Pyle method and hormonal tests showed low testosterone, LH, FSH, estradiol and beta-HCG.

CONCLUSION

The incidence of primary partial empty sella varies depending on means of diagnosis ranging from 5.5-35% in the general population. It may manifest with various endocrine deficiencies. Prepubertal hypogonadotropic hypogonadism is its main manifestation, presenting as micropenis and lack of secondary sexual characteristics. It is rare with peak incidence at late 30 to 40 years of age and predilection for females with female to male ratio of approximately 5:1.

KEY WORDS

empty sella, hypogonadism