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FINDING THE NEEDLE IN A HAYSTACK

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INTRODUCTION

Leydig cell tumours (LCT) of the ovary are rare ovarian tumours that usually present with hyperandrogenism. Radiological imaging is helpful in localizing these tumours. However, some tumours may be too small to localize before surgical exploration. When imaging is unrevealing, selective ovarian and adrenal venous sampling (SOAVS) is the next option. We report a case of LCT that was localized by SOAVS.

CASE

A 43-year-old nulliparous Chinese woman presented with a 6-month history of increased growth of terminal hair in the face, chest, abdomen and thighs, associated with deepening of voice, secondary amenorrhea and clitoromegaly. Laboratory investigations showed markedly elevated serum total testosterone of 32.11 nmol/L. Dehydroepiandrosterone sulfate was normal at 4.97 umol/L. ACTH stimulation test for 17-OH progesterone was normal (0 minutes: 4.2 nmol/L; 60 minutes: 7.9 nmol/L). Pelvic ultrasound revealed a small right ovarian cyst measuring 2.1x1.6 cm. CT abdomen and pelvis was normal. FDG-PET showed mild right adnexal FDG hypermetabolism which is within physiological limit. SOAVS was performed to localize the tumour. The total testosterone level in the right ovarian vein was reported to be 1027 nmol/L, while in the left ovary was 26.06 nmol/L. Laparoscopic right salpingo-oophorectomy was done and histopathology confirmed LCT. Post-surgery, her symptoms resolved and testosterone normalized.

CONCLUSION

SOAVS is a useful diagnostic modality that can help localize small ovarian tumours that are otherwise elusive to other imaging techniques.

KEY WORDS

selective ovarian and adrenal venous sampling, Leydig cell tumours, hyperandrogenism

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LATE DIAGNOSIS OF MALE HYPOGONADOTROPIC HYPOGONADISM: A POSSIBLE CASE OF KALLMANN SYNDROME?

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INTRODUCTION

Hypogonadism is a clinical syndrome characterized by disturbance of sexual organ functions and quality of life which is caused by androgen deficiency. While hypergonadotropic hypogonadism is the most frequent form of hypogonadism in male, hypogonadotropic hypogonadism is rare.

CASE

A 21-year-old male was referred to the endocrinology clinic with a problem of micropenis.While he had never reached puberty, anosmia and recurrent nasal congestion were present. His younger brother had similar complaints. Physical examination showed that he was in Tanner Stage I for Sexual Maturity Rating. In addition, gynecomastia, long arms and legs, and lack of skeletal muscle development (eunuchoidism) were observed. Genitalia examination showed no pubic hair; separated scrotums; testes with diameter of 1.5 cm; and penis with length of 2 cm without epispadia or hypospadia. While his testosterone, FSH, and LH levels were low, prolactin, fT4, TSH levels were within normal limits. No abnormalities were observed in the pituitary MRI imaging.

CONCLUSION

Early diagnosis and proper treatment in the case of delay/absence of signs of puberty is of paramount importance. The presence of anosmia or hyposmia concurrent with hypogonadotropic hypogonadism might indicate the presence of Kallmann syndrome.

KEY WORDS

delayed puberty, hypogonadotropic hypogonadism, micropenis, Kallmann syndrome