PP-P-09

A CASE OF A TSH AND GH CO-SECRETING PITUITARY MACROADENOMA IN A 56-YEAR-OLD FILIPINO WOMAN

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CASE
A 56-year-old Filipino female with gradual development of acromegalic features consulted for an enlarging goiter, associated with palpitations, heat intolerance, and weight loss. Thyroid function tests showed persistently elevated FT4, FT3, and TSH levels, despite the use of thioamides. Cranial MRI showed a 2.2 x 2.7 x 2.2 cm complex sellar-suprasellar mass with extension to nearby structures. A hormonal work-up confirmed growth hormone secretion, with associated hypocortisolism and hypogonadotropic hypogonadism. Thyroid ultrasound showed multiple nodules suspicious of malignancy. Octreotide-LAR 30 mg was given, rendering the patient euthyroid prior to total thyroidectomy. Histopathology showed multinodular colloid adenomatous goiter. TSH remained elevated despite levothyroxine replacement. She then underwent transsphenoidal excision of the pituitary mass. Post-operatively, levels of TSH and GH decreased significantly, despite the presence of tumor residuals. To our knowledge, this is the first reported case of a co-secreting TSH and GH pituitary macroadenoma in the Philippines. This case highlights the importance of multidisciplinary care in managing plurihormonal pituitary tumors.

KEYWORDS
pituitary tumor, TSH secreting, gh secreting, acromegaly, multinodular goiter, secondary hyperthyroidism, hypocortisolism, hypogonadotropic hypogonadism, total thyroidectomy, transsphenoidal excision, plurihormonal pituitary tumor

PP-P-10

PANHYPOPITUITARISM AND CEREBRAL SALT WASTING IN A 19-YEAR-OLD FILIPINO MALE WITH ASEPTIC MENINGITIS: A CASE REPORT

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CASE
A 19-year-old Filipino male had a fever, headache and decreased sensorium. Cranial MRI showed diffuse leptomeningeal enhancement without a discrete mass or hemorrhage. The sella was unremarkable. He had elevated opening pressure upon lumbar puncture. Ceftriaxone, anti-Koch's, dexamethasone, and mannitol were started.

He had severe hyponatremia (108 mg/dl) and seizure episodes. Workup showed low TSH (0.37 uIU/ml), fT3 (1.61 pg/ml), fT4 (0.82 ng/dl), and low serum cortisol (1.9 mg/dl). Additional hormone testing revealed low IGF-1 (102 ng/ml), FSH (0.65 mIU/ml) and free testosterone (0.178 ng/ml = 2.96%). Dexamethasone was continued. Levothyroxine was started. His serum sodium improved with no recurrence of seizures.

On the 3rd week, even after mannitol discontinuation, he became clinically dry, relatively hypotensive (90/60 mmHg), and hyponatremic (131 mg/dl) with increased urine output at 200–300 ml/hr. The workup showed serum osmolality of 287 mOsm/kg, elevated urine osmolality at 509 mOsm/kg, and elevated urine sodium of 187 mmol/L. He was given intravenous PNSS and 2% NaCl. He was also started on NaCl tablets and fludrocortisone. His serum sodium levels improved and his blood pressure normalized. He was eventually discharged stable.

KEYWORDS
panhypopituitarism, cerebral salt wasting, hyponatremia