PP-P-11

INVASIVE CORTICOTROPH PITUITARY MACROADENOMA: CASE REPORT AND LITERATURE REVIEW

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CASE
A 57-year-old Thai female presented with severe hypertension and generalized edema 5 months ago. She developed proximal muscle weakness, and bitemporal hemianopia 2 months prior to admission. She had moon facies, facial plethora and purplish abdominal striae. In addition, she had accentuated hyperpigmentation on the skin creases and knuckle areas. Biochemical results were compatible with adrenocorticotropic hormone (ACTH)-dependent Cushing's syndrome. Magnetic resonance imaging demonstrated a 5.9 x 5.1 x 6.7 cm pituitary macroadenoma, extending to the cavernous sinus and left optic tract. Transsphenoidal pituitary tumor resection was performed. Histopathology confirmed a pituitary adenoma with positive staining for ACTH and somatostatin. Follow-up MRI showed residual tumor, hence adjuvant radiotherapy was given. Based on the 2022 PitNET WHO classification, she is categorized as having an invasive and non-proliferative corticotroph pituitary tumor. Three years after surgery, there was still no evidence of tumor progression.

KEYWORDS
Cushing's syndrome, pituitary macroadenoma, ACTH, proximal muscle weakness, corticotroph

PP-P-12

DIFFUSE LARGE B-CELL LYMPHOMA WITH ISOLATED CENTRAL NERVOUS SYSTEM RELAPSE WITH COMPLETE CENTRAL DIABETES INSIPIDUS: CASE REPORT AND LITERATURE REVIEW

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CASE
A 35-year-old Thai female was diagnosed with diffuse large B cell lymphoma (DLBCL) stage IV with CNS involvement in March 2021. She was lost to follow-up after chemotherapy. In October 2022, she presented with cauda equina syndrome and subsequently received whole-brain therapy. She developed complete central diabetes insipidus (DI) and secondary hypothyroidism nine months later. The hypothalamic-pituitary-adrenal axis remained intact at that time. MRI of the brain revealed a faint posterior pituitary bright spot, intact pituitary stalk, and brain parenchymal involvement compatible with disease progression. One month after brain radiotherapy, she developed adrenal insufficiency (AI). We reviewed a series of cases similar to our patient with DLBCL relapse, isolated CNS involvement, initial DI and hypothyroidism, and subsequent AI. We suggest careful evaluation of pituitary function in patients with DLBCL with CNS involvement for early diagnosis and optimal pituitary hormone replacement therapy.

KEYWORDS
diffuse large B cell lymphoma, hypopituitarism

PP-P-13

MACROPROLACTINOMA PRESENTING WITH PITUITARY APOPLEXY: A CASE REPORT AND LITERATURE REVIEW

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CASE
A 59-year-old female with no illness or medications presented with a thunderclap headache and bitemporal hemianopia for one week. Visual acuity was reduced to finger counting OS. MRI revealed a 2 x 3 x 3 cm cystic-solid lesion with internal hemorrhage at the sellar-suprasellar region with superior displacement of optic chiasm and optic tract. Tests showed serum prolactin 209.9 ng/mL [1:100 dilution, 72% recovery after PEG precipitation (reference >60%)]; normal TSH; and low FT4, IGF-I, FSH and serum cortisol, consistent with pituitary macroadenoma with apoplexy, optic chiasm and optic nerve compression, central hypothyroidism, secondary adrenal insufficiency and hyperprolactinemia from stalk effect. Endoscopic endonasal surgery revealed a blood clot. Visual symptoms did not improve. Post-operative serum prolactin was 213 ng/mL. She was treated as a pituitary neuroendocrine tumor (PitNET) with PIT1 lineage of lactotroph tumors which express dopamine D2 receptor. She was managed medically with a dopamine agonist.

KEYWORDS
PitNET, pituitary apoplexy, hyperprolactinemia, macro-prolactinoma, pituitary adenoma