

(TFT), with elevated free-T4 (range: 24.3-34.3 pmol/L) and non-suppressed thyroid stimulating hormone (TSH) (range: 1.19-4.07 mIU/L), similar across different laboratory platforms. Serum alpha-subunit of TSH was 0.6 IU/L, with TSH molar ratio of 3.1. Morning cortisol level was normal (598 nmol/L). Other pituitary hormones were appropriate for age and postmenopausal status. Whole body CT-scan was negative for malignancy, but incidentally showed a sellar mass. MRI confirmed a sellar mass measuring 1.1 x 2.1 x 2.1 cm, with suprasellar and cavernous extension, and chiasmal compression, with no features of apoplexy. Posterior pituitary T1 bright spot was present and displaced posteriorly.

Her hyponatremia improved with fluid restriction and rescue doses of tolvaptan. The sellar tumour was resected trans-sphenoidally. Histopathological examination confirmed a diagnosis of pituitary adenoma, which stained negative for ACTH, GH and PRL. TSH-staining was unavailable. Postoperatively, her TFT and sodium levels normalized.

CONCLUSION

Hyponatremia is a rare presentation for pituitary adenomas, especially in the absence of hypocortisolism or hypothyroidism. SIAD has been reported in non-functioning pituitary adenomas, pituitary apoplexy and central hypothyroidism and hypocortisolism. This is postulated to be due to exaggerated arginine-vasopressin (AVP) secretion due to local mass effect.

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GIANT PITUITARY MACROADENOMA MASKED BY BILATERAL RETINAL DETACHMENT

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INTRODUCTION/BACKGROUND

Pituitary adenomas are benign tumours that encompass 10-20% of intracranial neoplasms. About 25-35% are clinically non-functioning pituitary adenomas (NFPA). Giant pituitary adenomas (diameter ≥ 4 cm) comprise approximately 5% of all pituitary tumours and usually present with mass effects on the neighbouring structures causing visual impairments, headaches and cranial nerve dysfunction. We present a case of giant pituitary macroadenoma with late presentation, being masked by bilateral retinal detachment.

CASE

A 39-year-old male with past history of bilateral retinal detachment following motor vehicle accident presented with progressive deteriorating vision for the past 3 years. This was initially attributed to retinal detachment/retinal scar. He then had frequent falls and headaches for the past 2 months. Cranial MRI showed a large pituitary adenoma measuring 6.3 x 5.7 x 5.9 cm with compression to the frontal and parietal lobes, optic chiasm and lateral ventricles bilaterally. He underwent two debulking surgeries. Post-surgery imaging showed minimal changes in tumour size. Histopathology examination showed pituitary adenoma with low ki67. Clinically and biochemically, he had panhypopituitarism with thyroid stimulating hormone (TSH), adrenocorticotropic hormone (ACTH) and gonadotrophins insufficiency. He is now on thyroxine, hydrocortisone and testosterone replacement. A multidisciplinary team meeting discussion concluded that a third debulking surgery by a high-volume surgeon followed by radiotherapy is the best option for the patient.

CONCLUSION

This is a case of NFPA complicated by progressive visual impairment which was masked by bilateral retinal detachment. We highlight the difficulty of detecting NFPA early in this patient in view of his visual history.

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RESOLUTION OF CYSTIC MACROPROLACTINOMA WITH DOPAMINE AGONIST THERAPY

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INTRODUCTION/BACKGROUND

Cystic prolactinomas are prolactinomas that harbor cystic regions, usually occupying $\geq 50\%$ of the tumour volume. It is hypothesized that dopamine agonists are ineffective in reducing cystic tumour mass due to the absence of dopamine receptors in the cystic portion of the tumour. We present a case of a patient with a cystic prolactinoma for which the cyst disappears following treatment with dopamine agonist.

CASE

A 23-year-old Malay female first presented with secondary amenorrhoea. She attained menarche at 15 years of age and had regular menses since then until 2019. She is otherwise