RESULTS
Responses were obtained from 33 endocrinologists. The majority (81%) used reference limits given rather than a fixed cut-off of 700 m IU/L and 70% used a sex-specific range. More than half (69%) favoured that the laboratory should screen for macroprolactin in all samples with high prolactin. On report format, 61.5% preferred the use of post-PEG monomeric reference ranges and 100% required the laboratory to indicate the presence of macroprolactin.

CONCLUSION
The laboratory working group will consider the responses from endocrinologists in preparing the consensus recommendations on reporting macroprolactin and the reference intervals.

EP_A122

UNVEILING PITUITARY PARADOX: OCTREOTIDE LONG-ACTING RELEASE (LAR) INDUCED APOPLEXY IN POST-OPERATIVE RESIDUAL MACROADENOMA

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Lee Hoong Hong, Kian Guan Goh, Mohd Syazwan Amin
Hospital Tengku Ampuan Afzan, Malaysia

INTRODUCTION/BACKGROUND
The development of a somatostatin analogue (SSA) has revolutionized the treatment of acromegaly. Octreotide LAR is a long-acting release formulation of SSA, often used as an alternative when surgery is not possible in patients with acromegaly or as an adjuvant therapy in post-operative patients with residual pituitary adenoma. Pituitary apoplexy, characterized by infarction or bleeding of the pituitary gland, is a rare condition.

CASE
An 18-year-old male with a clinical and biochemical diagnosis of acromegaly underwent transsphenoidal surgery in November 2021 with incomplete tumour resection, complicated by pituitary apoplexy after administration of octreotide LAR.

Post-operatively, he had residual pituitary adenoma with optic chiasm compression and persistent elevations of insulin-like growth factor 1 (IGF-1) (1.7x > upper limit of normal) and growth hormone (GH) level (10x > normal limit). After extensive discussion, the patient was started on medical treatment, cabergoline 0.5 mg twice weekly, but failed to achieve biochemical control despite continued use for 9 months. Subsequently, octreotide LAR 30 mg monthly was started, aiming to achieve better biochemical control and shrink the tumour size while awaiting stereotactic radiosurgery.

Unfortunately, 6 weeks after the first injection of octreotide LAR, he developed a sudden severe headache and visual disturbance, presenting clinically with bitemporal hemianopia, subsequently diagnosed with pituitary apoplexy on cranial MRI. Octreotide LAR was discontinued. Patient underwent repeated transsphenoidal surgery, which was uncomplicated, albeit with pre-existing central hypothyroidism and hypocortisolism.

CONCLUSION
Pituitary apoplexy is one of the rare complications of SSA. However, clinicians need to maintain a high level of suspicion for this complication if the patient presents with sudden headache with or without neuro-ophthalmic signs after receiving SSA, given its significant morbidity and potential fatality.

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A RARE CASE OF ECTOPIC GIANT PROLACTINOMA MIMICKING CLIVAL CHORDOMA

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Kai Xuan Teh, Hwee Ching Tee, Jin Hui Ho
Endocrinology unit, Department of Internal Medicine, Hospital Queen Elizabeth II, Kota Kinabalu, Sabah, Malaysia

INTRODUCTION/BACKGROUND
Ectopic pituitary adenomas are extremely rare tumours which develop outside the sella turcica. The most common locations are the sphenoid sinus, clivus, suprasellar space, nasopharynx and cavernous sinus. Due to their rarity, these tumours are frequently misdiagnosed as other skull lesions such as chordoma, chondrosarcoma, meningioma or astrocytoma. We present a case of ectopic giant prolactinoma mimicking as clival chordoma.

CASE
A 38-year-old nulliparous female presented with oligomenorrhoea since the age of 20 and secondary amenorrhea at the age of 38 associated with galactorrhoea. Otherwise, she denied headache, symptoms of increased ICP or blurring of vision. There were no other symptoms to suggest pituitary hyper- or hypofunction. Her initial hormonal work-up showed hyperprolactinemia (>8000 ng/mL) with hypogonadotropic hypogonadism. MRI of the brain was signed out as clival chordoma measuring 2.3 x 3.6 x 4.1 cm displacing the pituitary gland and