Treatment with antibiotics and intravenous hydrocortisone, followed by thyroxine and testosterone therapy, resulted to clinical improvement, including improvement of GCS with resolution of the prostatic abscess, visual field deficit, and erectile dysfunction. Follow-up imaging showed a decrease in the size of the sellar mass (1.5 × 1.7 × 1.5 cm), hence the neurosurgery team opted for conservative management with continued endocrine follow-up.

CONCLUSION

The importance of addressing male sexual dysfunction without stigma is highlighted by this case. Non-functioning pituitary macroadenomas commonly affect the hypothalamic-pituitary-gonadal axis, and concurrent fever may mask an underlying infection. This infection, in turn, could trigger pituitary apoplexy. Clinicians should maintain a high index of suspicion and intervene promptly in patients presenting with elevated intracranial pressure to ensure optimal outcomes.

EP_A112

A CASE OF PROLACTIN AND GROWTH HORMONE CO-SECRETING PITUITARY MACROADENOMA

https://doi.org/10.15605/jafes.040.S1.120

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INTRODUCTION/BACKGROUND

Prolactin (PRL) and growth hormone (GH) co-secreting pituitary macroadenomas are relatively rare and exhibit a multifaceted clinical presentation. Optimal management of PRL/GH co-secreting pituitary adenomas remains clinically challenging. We report a case of a PRL/GH co-secreting pituitary macroadenoma managed with cabergoline monotherapy.

CASE

A 25-year-old male without comorbidities presented with a chronic headache for eight years. Pituitary MRI revealed a pituitary macroadenoma measuring 1.7 x 2.5 x 1.8 cm compressing the optic chiasm, with minimal extension into the right cavernous sinus and mild sellar widening. He had markedly elevated prolactin at 11,170 mIU/L and was started on Cabergoline 0.25 mg twice weekly and transferred care to our centre for further management of functioning pituitary macroadenoma. Notable physical examination findings included frontal bossing and prognathism, but no macroglossia, skin tags, or tremors were seen. A visual field assessment revealed no defects. Hormonal workup exhibited elevated GH of 4.75 µg/L (5x the upper limit of normal), IGF-1 of 418.9 ng/mL, prolactin of 3,433 mIU/mL and failure of GH suppression on OGTT, consistent with a GH and prolactin-secreting pituitary adenoma. The multidisciplinary team reached a consensus that curative surgery is not feasible due to tumor extension into the right cavernous sinus. They recommended increasing his Cabergoline dosage to 3-4 mg weekly. The patient remains asymptomatic and his prolactin level is 784 mIU/mL while on Cabergoline 3.5 mg weekly. A follow-up MRI shows a smaller pituitary lesion with resolution of the optic chiasm mass effect. Currently, the patient is not inclined to consider surgery.

CONCLUSION

Surgical intervention is typically the first-line treatment for mixed co-secreting pituitary adenomas. However, cabergoline is known to effectively normalize prolactin levels in patients with hyperprolactinemia caused by mixed adenomas. In this particular case, cabergoline monotherapy appears to be successful at controlling both tumor growth and prolactin levels.

EP_A113

EFFECTIVE MEDICAL THERAPY FOR MULTIPLE ENDOCRINE NEOPLASIA TYPE 1-ASSOCIATED METASTATIC VIPoma

https://doi.org/10.15605/jafes.040.S1.121

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INTRODUCTION/BACKGROUND

Pancreatic islet cell tumors occur in 40% of MEN 1 patients. VIPoma is a rare functioning pancreatic neuroendocrine tumor characterized by excessive secretion of vasoactive intestinal peptide (VIP), with an annual incidence of fewer than 1 in 10 million in the general population. Most cases are sporadic, but about 5% are linked to multiple endocrine neoplasia type 1 (MEN 1) syndrome. We describe a patient with MEN 1 associated metastatic VIPoma.

CASE

A 56-year-old female was first diagnosed with a benign insulinoma in 2005 and underwent successful laparoscopic tumor excision. There was no prior or family history of endocrine tumors. In 2019, she developed intermittent abdominal pain and chronic diarrhea which progressed over a 3-year period.