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.

Adult E-Poster

In 2022, investigations confirmed elevated vasoactive intestinal peptide (VIP) levels of 276 pg/mL (normal reference: <75 pg/mL) and a pancreatic body tumor with diffuse pancreatic infiltration, as well as liver and nodal metastases were identified on multimodal imaging. Extensive debulking surgery was recommended, but the patient declined.

In March 2023, she presented to our hospital with hypovolemic shock resulting from profuse diarrhea and severe hypokalemia. Intramuscular octreotide long-acting release (LAR) 30 mg was initiated, leading to prompt symptom control, and she continued to receive monthly injections. Genetic studies confirmed multiple endocrine neoplasia type 1 (MEN 1), prompting subsequent screening of family members.

By March 2024, the patient was asymptomatic, had experienced significant weight gain (from 50 to 65 kg), and her VIP levels had normalized to 66 pg/mL. A Gallium-68 (Ga-68) DOTATATE PET/CT scan in March 2024 demonstrated stable pancreatic and nodal disease but progressive liver metastases. The neuroendocrine multidisciplinary team offered the option of peptide receptor radionuclide therapy (PRRT), but she declined this treatment.

CONCLUSION

This case highlights the effectiveness of medical management with Octreotide LAR for control of symptoms and tumor-related hormonal hypersecretion in inoperable metastatic VIPoma regardless of disease progression. A personalized multidisciplinary approach is a pre-requisite for achieving optimal outcomes.

EP_A114

THE SHRINKING HYPOTHALAMIC LESION: SERIAL MRI-GUIDED MANAGEMENT OF REFRACTORY XANTHOMATOUS HYOPHYSITIS

https://doi.org/10.15605/jafes.040.S1.122

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INTRODUCTION/BACKGROUND

Xanthomatous hypophysitis is a rare inflammatory condition affecting the pituitary gland, characterized by the presence of lipid-laden macrophages (xanthoma cells) and chronic inflammation.

CASE

We describe a 26-year-old female with a 12-year history of xanthomatous hypophysitis complicated by panhypopituitarism and diabetes insipidus. Initial presentation at age 13 years with growth failure led to transcranial tumor debulking in 2016, with histopathology confirming chronic xanthogranulomatous inflammation. Due to recurrent disease activity, she received two courses of high-dose prednisolone (2018 and 2019-2020), followed by maintenance azathioprine (initiated 2020, currently 25 mg daily).

Serial MRI surveillance showed a gradual regression of the lesion over time. In July 2023, the hypothalamic lesion measured 1.3 × 0.8 × 0.8 cm, a reduction from its previous size of 1.5 × 1.3 × 1.1 cm in 2021. This regression was accompanied by decreased compression on the optic chiasm. The pituitary gland remained thinned, and the posterior pituitary bright spot is absent, consistent with long-standing structural damage. These findings suggest ongoing inflammatory control under azathioprine.

Hormonal management included levothyroxine (37.5 mcg/day), sublingual desmopressin (60 mcg/day for DI), and cyclic estrogen-progestin (Progyluton). Adrenal function recovered post-steroid withdrawal, confirmed by a normal Synacthen test (peak cortisol 624 nmol/L, 2022). Complications included secondary osteoporosis (spine T-score -1.8, hip -2.5) managed with calcium/vitamin D, and microcytic anemia (Hb 9.4 g/dL, MCV 29.8 fL), likely due to iron deficiency, now treated with oral iron and folate.

CONCLUSION

This case highlights the chronic relapsing-remitting nature of xanthomatous hypophysitis, necessitating long-term immunosuppression and meticulous endocrine surveillance. The latest MRI findings (2023) confirm disease stability under azathioprine, supporting its role in preventing progression. However, residual hypothalamic involvement underscores the need for continued monitoring. A multidisciplinary approach (endocrinology, neurosurgery, rheumatology) remains essential to manage hormonal deficits, bone health, and potential disease recurrence. Future considerations include azathioprine tapering if imaging remains stable, emphasizing the importance of serial MRI in guiding therapy.