CONCLUSION

APS-2 as an evolving polyglandular disease may be associated with other endocrine deficiencies, including central DI. Loss of pituitary bright spot and stalk thickening on MRI supports the diagnosis of central DI and should be considered in the work up of patients.

PP-PN-10

A CASE REPORT ON PITUITARY APOPLEXY FOLLOWING ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY AND LAPAROSCOPIC CHOLECYSTECTOMY

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BACKGROUND

Pituitary apoplexy is a rare neurosurgical emergency increasingly being precipitated by minor surgical procedures.

CASE

A 49-year-old male underwent ERCP and laparoscopic cholecystectomy for acute cholangitis. Two days post-operatively, he complained of dizziness with horizontal diplopia and slight left eye ptosis. Five days postoperatively, he became drowsy, with complete ptosis and blurred vision of the left eye and decreased motor strength on all extremities. Cranial CT Scan showed a sellar/suprasellar ovoid soft tissue focus. Pituitary MRI confirmed a sellar/suprasellar heterogeneous mass measuring 1.5 cm x 2.5 cm x 1.8 cm, hyperintense on T1 and hypointense on T2. Hormonal workup showed low IGF-1 [63.50 ng/mL, reference value (RV) 74-196], GH (0.60 ng/mL, RV 0-0.97), LH (0.16 mIU/mL, RV 1.5-9.3). total testosterone (<10 pg/mL, RV 164-753), ACTH (<5 pg/mL, RV 5-46), 0800H cortisol (<1.00 µg/dL, RV 3.7-19.4), PRL (1.11 ng/mL, RV 2.1-17.7), TSH (0.23 uIU/mL, 0.55-4.78) and FT3 (2.23 pg/mL, RV 2.3-4.2). He was managed as panhypopituitarism (secondary adrenal insufficiency, hypothyroidism, hypogonadism) secondary to pituitary macroadenoma with pituitary apoplexy. He was given hydrocortisone and underwent endoscopic transsphenoidal pituitary mass excision. He was discharged improved on prednisone 7.5 mg/day and levothyroxine 100 µg/day.

CONCLUSION

Pituitary apoplexy should be considered in patients with abrupt neuro-ophthalmological deterioration even after minor gastrointestinal surgeries. Early diagnosis allows immediate intervention to preserve vision and provide hormonal replacement.

PP-PN-11

A CONCURRENT FINDING OF A GROWTH HORMONE-PRODUCING PITUITARY ADENOMA AND A RADIOLOGICALLY-CONFIRMED SYMPTOMATIC RATHKE'S CLEFT CYST

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BACKGROUND

We present a case report describing a rare finding of concurrent growth hormone (GH)-producing pituitary adenoma and a radiologically confirmed symptomatic Rathke's cleft cyst (RCC) in a 65-year-old female patient.

CASE

Hormonal studies showed elevated insulin-like growth factor (IGF) [43.3 nmol/L, reference range (RV) 6.2-24 nmol/L and 51.3 nmol/L] taken two months apart. Other assays were normal (PRL 213 mIU/L, RV <700; 1000H cortisol 222 nmol/L, RV 14-690; TSH 1.3 mIU/L, RV 0.27-4.2; FT4 12 pmol/L, RV 12-22 pmol/L). OGTT revealed a failure to suppress serum GH to <1 µg/L, with nadir GH 2.3 µg/L. Pituitary meatus magnetic resonance imaging scan showed a 6.5 mm x 9 mm non-enhancing cyst in the pituitary sella which appeared to be displacing the normal pituitary tissue superiorly and slightly posteriorly. The optic chiasm was preserved, with no supra- or parasellar extension. After transphenoidal surgery, histolopathologic studies revealed a strongly GH-positive adenoma, also positive for PIT1, SF1; and Ki67 1-2%. PRL, FSH and LH staining were negative.

CONCLUSION

Clinicians are reminded about increasing evidence of the concurrent occurrence of symptomatic RCC(s) and pituitary adenoma(ta). More explanations beyond case reports or case series evidence are needed to explain their seeming concurrence.