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CASE OF PITUITARY APOPLEXY IN PROBABLE NEWLY DIAGNOSED ACROMEGALY.

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A 24 years-old lady with no known medical illness, presented with severe headache mainly at frontal area. It is sudden in onset and has been worsening for the last 1 week. There was no aura and no precipitating and alleviating factor . Upon further history, she has 10 years history of generalized throbbing headache mainly on left side since 15 years old which was thought due to migrane. She also just received Astra Zeneca vaccine 7 days prior to presentation. She denies blurring of vision, eye pain, diplopia and galactorrhea and her menstrual cycle has been regular. She noted gradual weight increment 3-4kg within 6 months. Otherwise there was no easy bruising and she denies postural dizziness , lethargy and there was no symptoms of hypothyroid/hyperthyroidism.

Initial assessment showed that she is overweight with weight of 72kg and BMI 29. She is euglycemic and normotensive with no postural hypotension. Confrontational visual field assessment was normal with no bitemporal hemianopia. There was no sings of Cushing's disease or Acromegaloid features.

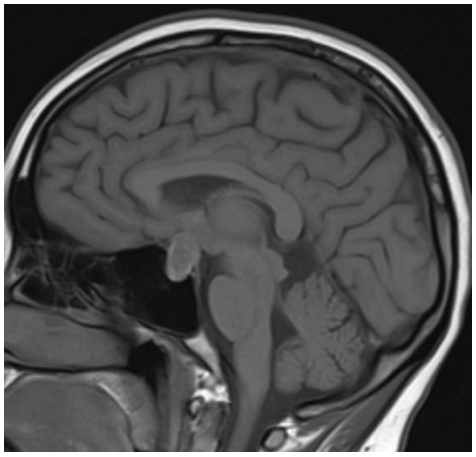
Blood investigation showed normal FBC, RP and LFT, in which Na was 139 and K 4.6. Hormonal workout was done and the result showed normal anterior pituitary hormone levels except IGF-1 which is raised at 417 ng/ml. MRI brain shows heterogenous enhancing sellar lesion extending to the suprasellar region measuring approximately 1.1cm x 1.6 x 1.9cm (AP x W x CC). It is hypointense centrally with high signal in the periphery on T1W images, heterogenous, hyperintense signal on T2WI with areas of low signal within. The features are suggestive of pituitary apoplexy with mass effect to the optic chiasm and cavernous portion of the left ICA.

Before the IGF-1 result was revealed, initial diagnosis of pituitary apoplexy with non-functioning pituitary macrodenoma in view of absent sign and symptoms of hyperfunctioning anterior pituitary hormone. However, prevalence of NFPA normally occurs in older age; 4^{th} to 7^{th} decade of life. Hence, other diagnosis should be sought in younger patient presented with pituitary macroadenoma rather than NFPA.

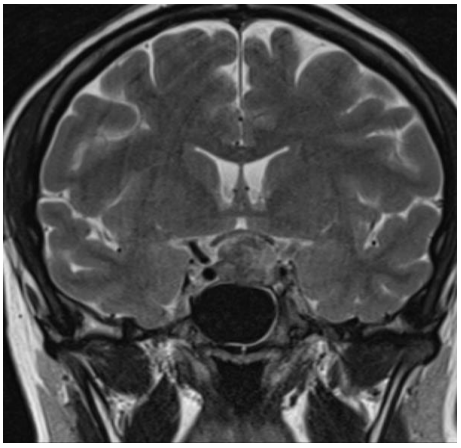
A diagnosis of pituitary macroadenoma- likely due to acromegaly with pituitary apoplexy was made. She was treated with IV hydrocortisone 50mg QID and the symptoms improved. She was discharge with tapering dose of hydrocortisone was planned to start with SC octreotide while awaiting surgery.

Key learning points:

- A diagnosis of pituitary apoplexy should be considered in all patients presenting with acute severe headache with or without neuro-ophthalmic signs
- NFPA mostly occurs in older age population ; 4^{th} – 7^{th} decade of life.
- Prompt HCT treatment in patient with suspected pituitary apoplexy
- Options for medical vs surgical treatment – to discuss with the patient
- Long term follow up is needed to detect recurrence of pituitary tumour



MRI scan T1 non contrast showed a ring of hyperintense signal surrounding pituitary.



MRI scan T2 with contrast showed heterogenous, hyperintense signal on T2WI with areas of low signal within.