

Unusual cause of menorrhagia

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DESCRIPTION

A 37-year-old woman presented to her general practitioner (GP) with a history of intermittent galactorrhoea and amenorrhoea. She reported intermittent expression (5 mL) from both breasts, which have been present following her last pregnancy 4 years ago. In addition she reported tension headaches with no visual disturbances and left-sided nasal obstruction which was treated with prescribed fluticasone nasal spray.

Following an episode of menorrhagia, the patient presented to her GP and routine blood tests were performed, which included haemoglobin 12.0 g/dL, mean corpuscular volume 81.4 fL, white cell count $8.9 \times 10^9/L$, platelets $304 \times 10^9/L$, sodium 143 mmol/L, potassium 3.6 mmol/L, serum luteinizing hormone level: 0.2 U/L (2.9–21.7 U/L), serum follicle-stimulating hormone level: 10.1 U/L (2.5–19.5 U/L), serum prolactin 3428 mU/L (25–629 U/L). The GP requested an MRI scan which revealed a $4.4 \times 4.6 \times 2.7$ cm lesion filling the central sphenoid air sinus, pituitary lesion or nasal polyp (figure 1).

The patient reported a background of hypertension which is currently well controlled on amloride 10 mg once daily and lisinopril 20 mg once daily.

She denies any endocrinopathies in her family history. She was referred to St Bartholomew's Hospital, endocrinology department and given a trial single dose of cabergoline 0.5 mg which significantly suppressed the levels of prolactin from 3428 to 280 mU/L. Nasal biopsy revealed null cell pituitary adenoma with a Ki67 index $<1\%$.

Initially we were keen to manage this medically as the patient did not report any visual deficit.¹ However, as she continued to report left nasal obstruction, spontaneous tension headaches and the issue of the prolactinoma penetrating the sellar floor and filling the central air sinus suggested that she may benefit from nasal debulking followed by trans-sphenoidal surgery for pituitary debulking.¹

Overall, this was a very interesting case; normally such patients would be treated medically; however, due to the size and impact the pituitary mass had on the patient's quality of life the overall decision made by the patient and multidisciplinary team to opt for surgery which eliminated any future risk of optic chiasmal compression and improved patient's quality of life. There were no complications during the surgical procedures and the patient's symptoms have fully resolved.



Figure 1 MRI scan which reveals a $4.4 \times 4.6 \times 2.7$ cm lesion filling the central sphenoid air sinus.

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Learning points

- ▶ In a patient with inappropriate galactorrhoea—check the prolactin.¹
- ▶ MRI scanning is essential.¹
- ▶ Trial of cabergoline therapy may help shrink tumour avoiding surgical intervention.¹

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