Rare case of hepatocellular carcinoma metastasising to the pituitary and cavernous sinus causing panhypopituitarism and bilateral ophthalmoplegia

Jayachidambaram Ambalavanan, Monica Peravali, David J Perry

SUMMARY
Pituitary metastases, especially from a primary hepatocellular carcinoma (HCC), are rare. Review of the literature revealed only few cases reporting pituitary metastases complicated by panhypopituitarism from HCC. Calvarial metastases from HCC are even more rare. Here, we present a unique case of primary HCC with metastases to both the calvarium and the pituitary causing panhypopituitarism and bilateral ophthalmoplegia, respectively. To our knowledge, this is the first reported case of two unique and rare complications from metastatic HCC.

BACKGROUND
Pituitary metastases are extremely rare. Sellar masses mostly comprise pituitary adenomas, while only 1%–2% of those masses are attributed to secondary metastases. When metastatic disease to the pituitary is present, it commonly arises from a primary breast or lung cancer.

While 18%-64% of hepatocellular carcinomas (HCCs) metastasise, the most common site is usually the lung. Brain metastasis is infrequent, and isolated pituitary metastasis is even more rare.

Symptoms from pituitary metastases are seen in 7% of cases, most commonly causing diabetes insipidus (DI) and headaches, signifying posterior pituitary involvement. Anterior pituitary dysfunction in the form of visual field defects and ophthalmoplegia is also a possible manifestation although less frequently seen.

A thorough review of the literature reveals few cases of primary HCC, with metastasis to pituitary involving cavernous sinus, clivus and sphenoid sinus with resultant panhypopituitarism and cranial nerve palsies. However, it is extremely rare for all these manifestations to occur at the same time.

To our knowledge, we present the first case of primary HCC with metastases to both the calvarium (with sphenoid sinus involvement) and the pituitary causing bilateral ophthalmoplegia and panhypopituitarism, respectively.

CASE PRESENTATION
A 68-year-old man with chronic hepatitis B, HIV on highly active antiretroviral therapy and history of anal cancer in remission for 3 years initially presented with headache, generalised weakness, abdominal pain, nausea and vomiting. Physical examination was consistent with left eye ptosis with difficulty in opening his eye, while the rest of his neurological examination was unremarkable.

INVESTIGATIONS
Initial labs were significant for haemoglobin (128 g/L), white cell count \((8.5\times10^9/L)\) and platelet count \((192\times10^9/L)\). HIV labs were significant for absolute CD4 count \((305\text{ cells}/\mu\text{L})\), CD4/CD8 ratio \((0.78)\) and HIV viral load \(<20\), indicating an intact immune system. He also had a mild transaminitis \((\text{aspartate aminotransferase}=98, \text{alanine aminotransferase}=33)\) and positive hepatitis B surface antigen and hepatitis B e-antigen. His hepatitis B viral DNA was 37603.

A sinus X-ray showed right lateral maxillary sinus thickening. Over the next few days, the patient developed abdominal pain with distension. CT of the abdomen and pelvis was done to rule out intestinal obstruction. It instead revealed multiple hypodense poorly defined clustered hepatic lesions with mild surrounding hyperenhancement with invasion of the portal vein by tumour thrombus, which could have contributed to the abdominal pain. MRI of the abdomen (figure 1) was also done to better visualise the liver. It revealed a large 8.7×8.5 cm\(^2\) lesion in the right posterior hepatic lobe. The differentials for the lesions at this point of time included HCC considering his hepatitis B status or atypical metastasis from anal cancer.

TREATMENT
Over the course of hospitalisation, the patient had alteration in mentation. His unilateral ptosis progressed rapidly to bilateral ptosis with complete ophthalmoplegia. CT of the head (figures 2 and 3) subsequently confirmed sphenoid sinus opacification with a mass in the pituitary invading into the cavernous sinus. Neurosurgery was consulted for brain mass with compressive symptoms, but surgical intervention was not possible due to the extent of tumour invasion around bilateral carotids. Hormonal studies were performed and revealed the following (table 1).

These were interpreted as showing panhypopituitarism. Once he started treatment with levotheroxine and dexamethasone, his mental status started improving.

Liver biopsy confirmed HCC (figures 4 and 5). Transsphenoidal biopsy of the pituitary lesion (figure 6) revealed concordant findings of HCC. He received palliative whole-brain radiation (3000
cGy) over a period of 10 days, which unfortunately did not reverse his ophthalmoplegia.

OUTCOME AND FOLLOW-UP
He was subsequently discharged to a subacute rehabilitation facility with plans for outpatient follow-up with oncology. Unfortunately, he died 2 weeks after discharge.

DISCUSSION
Pituitary metastasis is an extremely rare and life-threatening complication. As discussed earlier, most of the pituitary tumours are primary adenomas, and only 1%–2% of all pituitary tumours can be attributed to metastasis.1 2

HCC metastasising to the pituitary also is very rare. A recent study5 evaluating the epidemiology of HCC showed that less than 18% were associated with metastasis; moreover, lung was the most frequent site for metastasis. Another study showed that this prevalence could be as high as 64%.6 Despite a wide range of reported data on the incidence of metastatic HCC, only 11 cases of metastases to the pituitary have been reported in the current literature.7 14

Metastasis to the anterior pituitary is rarer than to the posterior pituitary. Less than 40% of all pituitary metastases are seen anteriorly likely due to several factors including differences in the blood supply of anterior pituitary (hypophyseal portal) and posterior pituitary (systemic circulation).15 Another possible mechanism could be the smaller size of the posterior pituitary, leading to earlier manifestations of symptoms even with low tumour burden.15

Posterior pituitary involvement causes DI and headache. The most common symptoms of anterior involvement include visual field deficits with cavernous sinus involvement, ophthalmoplegia and panhypopituitarism, which were all manifested in our patient.4 6

Another unique aspect of our case is the presence of bilateral ptosis and complete ophthalmoplegia with frozen globe. This occurred due to invasion of both cavernous sinuses and compression of cranial nerves III, IV and VI bilaterally, the extent of which has not been previously reported.9–12 Moreover, the tumour had also invaded the clivus and sphenoid sinus. Similar clivus involvement has been reported before with HCC but not together with ophthalmoplegia and panhypopituitarism.9 10 11 Interestingly, his optic nerve was intact bilaterally, which was reported in some cases.5

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Endocrine workup</th>
</tr>
</thead>
<tbody>
<tr>
<td>LH</td>
<td>FSH</td>
</tr>
<tr>
<td>1</td>
<td>3.64</td>
</tr>
<tr>
<td>TSH</td>
<td>Free T4</td>
</tr>
<tr>
<td>0.022</td>
<td>0.4</td>
</tr>
</tbody>
</table>

FSH, follicle-stimulating hormone; LH, luteinising hormone; TSH, thyroid-stimulating hormone.
Case report

Panhypopituitarism is an important manifestation from pituitary metastases, and having a high index of suspicion for early detection is key. Secondary hypothyroidism and adrenal insufficiency are important sequelae that can lead to rapid mortality from hypovolemic shock if not recognised and addressed early. Neuropsychiatric manifestations in the form of alteration in mentation, delusions and hallucinations have also been described in some cases, as was also noted in our case. Studies have shown that pituitary hormones, particularly cortisol and thyroxine, have a dominant effect on neurotransmitters of the brain such as serotonin, dopamine and gamma aminobutyric acid, and repleting them can reverse neuropsychiatric disturbances observed. Our case illustrates successful management of the life-threatening complication of pituitary metastasis given prompt recognition and early replacement of hormones with dexamethasone and levothyroxine.

Several options exist for the treatment of pituitary metastasis, including surgical resection, radiosurgery, radiation and chemotherapy. Increased vascularity and invasion of the cavernous sinus usually make surgical resection challenging, as in our case. Although palliative radiation is a viable option and the least invasive approach, it may not yield an adequate response with reversal of symptoms, as illustrated in our case. Despite prompt recognition of complications, mortality rate is high in pituitary involvement with average survival at 13.6 months.

Metastases from HCC lead to an even lower survival, as in our case. Unfortunately, our patient succumbed to his disease 2 weeks following his discharge, proving the aggressive nature of the disease.

Learning points

► Pituitary metastasis from hepatocellular carcinoma is an extremely rare and life-threatening complication.
► Clinicians must be aware of the symptoms of anterior pituitary metastasis and should not delay imaging of the brain.
► Extension of invasive tumour into the sphenoid and cavernous sinuses causes significant morbidity, as illustrated in our case.
► We present this unique case to underscore the importance of early recognition of panhypopituitarism in suspected cases of pituitary metastases.
► Replacement of hormones in a timely manner is essential in preventing haemodynamic compromise and subsequent mortality.

Acknowledgements We would like to acknowledge all the assistance offered by the pathologist and neuroradiologist for helping us with the histopathology slides and suitable imaging, respectively. We also like to thank our colleagues and attending physicians for guiding us throughout this process. Finally, we thank the patient himself for allowing us to learn from him.

Contributors JA was a part of the primary team taking care of the patient whose initial presentation was both unique and challenging clinically. MP and DJP were part of the oncology team who were consulted for the appropriate management of hepatocellular carcinoma. They were the ones who came with the idea for the case report and collaborated with the primary team for the report. The initial draft was made by JA who also made efforts to collect patient consent, clinical data, imaging and histopathological slides. After multiple edits and review by the oncology team, this manuscript is being submitted for review. We would also like to acknowledge the patient himself for consenting to publish his clinical data. In his words: "I would really want the medical community to learn more from patients like myself so that they can identify this disease early and treat appropriately"! We are extremely grateful to him.

Funding The Open Access cost of this publication was paid for by Medstar Health’s GME department.

Competing interests None declared.

Patient consent for publication Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.
Case report

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) licence, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: http://creativecommons.org/licenses/by-nc/4.0/.

ORCID ID
Jayachidambaram Ambalavanan http://orcid.org/0000-0001-6923-8728

REFERENCES

Copyright 2020 BMJ Publishing Group. All rights reserved. For permission to reuse any of this content visit https://www.bmj.com/company/products-services/rights-and-licensing/permissions/
BMJ Case Report Fellows may re-use this article for personal use and teaching without any further permission.

Become a Fellow of BMJ Case Reports today and you can:
► Submit as many cases as you like
► Enjoy fast sympathetic peer review and rapid publication of accepted articles
► Access all the published articles
► Re-use any of the published material for personal use and teaching without further permission

Customer Service
If you have any further queries about your subscription, please contact our customer services team on +44 (0) 207111 1105 or via email at support@bmj.com.
Visit casereports.bmj.com for more articles like this and to become a Fellow.