Pituitary apoplexy in a patient with suspected metastatic bronchogenic carcinoma

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Accepted 3 May 2014

We report the case of a 52-year-old man who was a chronic smoker and enjoyed good past health. He was admitted for progressive left-sided weakness and mild headache. He did not have any blurring of vision, diplopia or change in mental status. He was alert and his blood pressure was normal on admission. Cranial nerve examination was normal and his visual field was full. The limb power was Medical Research Council grade 4/5 over his left

Figure 1  (A) MRI T1-weighted image sagittal view with gadolinium contrast showing the pituitary gland is diffusely enlarged with suprasellar extension (arrow). (B) MRI T1-weighted image coronal view with gadolinium contrast showing the pituitary gland is diffusely enlarged with suprasellar extension (arrow). (C) MRI Gradient echo image showing blooming artefact (arrow) suggesting haemorrhage and pituitary apoplexy. (D) MRI T1-weighted image with gadolinium contrast showing a small rim-enhancing nodule with vasogenic oedema over corticomedullary junction of right supratentorial region (arrow) which was likely brain metastasis.

To cite: Man BL, Fu YP. BMJ Case Rep Published online: [please include Day Month Year] doi:10.1136/bcr-2013-202803
causing pituitary apoplexy is extremely rare. Since the patient refused surgical intervention, no biopsy was performed to confirm the diagnosis. The presence of supratentorial brain metastases together with suspicious right infrahi]

upper limb and 1/5 over left lower limb. The muscle tone was increased on the left side. The blood tests showed a normal complete blood picture, liver and renal functions. Pituitary hormonal profile revealed random cortisol 175 nmol/L (171–536), FT₄ 9.9 pmol/L (9–19), thyroid-stimulating hormone 1.0 μIU/mL (0.35–4.94), prolactin 273 μIU/mL (86–324), follicle-stimulating hormone 0.3 IU/L (1.5–12.4), luteinising hormone 0.1 IU/L (1.7–8.6) and testosterone 0.09 nmol/L (6.68–25.7). MRI showed the pituitary gland was diffusely enlarged with suprasellar extension and blooming artefact suggesting pituitary apoplexy (figure 1A–C). Two small rim-enhancing nodules over corticomedullary junction were noted over supratentorial regions of bilateral cerebral hemispheres which were likely brain metastases (figure 1D). MRI of the whole spine showed no metastasis but there was carinal lymphadenopathy which was compatible with underlying bronchogenic carcinoma. Chest X-ray found a right infrahi}

Learning points

- Pituitary apoplexy is a life-threatening clinical syndrome caused by the rapid enlargement of a pituitary tumour due to haemorrhage and/or infarction.
- About 14–22% of patients with radiologically identified pituitary haemorrhage have subclinical apoplexy with mild or no symptoms.
- Prompt neurosurgical intervention is needed in symptomatic patients.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES