CONCLUSION

This case demonstrates the aggressive and metastatic nature of SDHB-mutated PGLs. This group of patients require long term surveillance given the risk of developing new tumors even years or decades after primary tumor resection. It highlights the importance of genetic testing following pheochromocytoma surgery to guide targeted therapy, lifelong surveillance, and family screening within a multidisciplinary care approach.

EP_A122

PRUDENT MANAGEMENT OF MICROPROLACTINOMA IN A TRANSGENDER WOMAN ON FEMINIZING HORMONAL THERAPY

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INTRODUCTION

Gender-affirming hormone therapy (GAHT) for transgender women utilizes estrogen and an anti-androgen like cyproterone acetate (CPA) which can both lead to hyperprolactinemia. Although mild prolactin elevations are common, the development of prolactinomas in transgender women on GAHT is rare.

CASE

A 23-year-old trans-woman on self-purchased estradiol hemihydrate (17β-estradiol) 4 mg and CPA 12.5 mg daily for GAHT presented with galactorrhea. Investigations revealed markedly elevated prolactin at 2,369 mIU/L and elevated estradiol at 848 pmol/L. A pituitary magnetic resonance imaging (MRI) identified a 0.4 × 0.5 cm microprolactinoma.

She declined clinical advice to reduce her medication dose and continued on the same treatment. In the subsequent year, her peak prolactin was 1,383 mIU/L, and a repeat MRI showed the microprolactinoma remained stable. She continues to be on close clinical monitoring.

Transgender females experience approximately a fourfold higher rate of developing prolactinomas. The patient's choice to persist with GAHT reflects the challenges in managing gender dysphoria alongside medical complications. A recent paper by BJ Nolan et al. suggests using prolactin levels exceeding 2,000–3,000 mIU/L to guide further investigations including a pituitary MRI to rule out a prolactinoma. In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the GAHT. Normalization of prolactin levels have been reported after gonadectomy and CPA cessation in transgender females on GAHT, which suggests that CPA usage may be associated with higher risk of hyperprolactinemia compared to estrogen therapy.

CONCLUSION

This case highlights that GAHT can lead to development of prolactinomas. Prolactin monitoring and MRI investigations should be reserved for symptomatic patients, and for those with significantly elevated or increasing prolactin levels. While treatment using dopamine agonists have been reported, this case demonstrates that conservative management and close monitoring can be a viable approach for structurally stable microprolactinomas.

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DIAGNOSTIC AND THERAPEUTIC ROLE OF ENDOSCOPIC ULTRASOUND (EUS) IN A CT-NEGATIVE OCCULT INSULINOMA

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INTRODUCTION

A negative computed tomography (CT) scan does not preclude an insulinoma, as small lesions frequently remain undetected on conventional imaging. This case highlights the indispensable role of endoscopic ultrasound (EUS)—not just for localizing occult tumors, but as a definitive, minimally invasive therapeutic alternative to high-risk surgical resection.

CASE

A 39-year-old female with underlying hypertension presented with a 5-month history of predominantly fasting hypoglycemia (glucose <3.0 mmol/L) and neuroglycopenic symptoms, fulfilling Whipple's triad. A supervised 72-hour fast confirmed endogenous hyperinsulinemic hypoglycemia at 31 hours, with a nadir glucose of 1.4 mmol/L, insulin 116 pmol/L, and C-peptide 821 pmol/L. Notably, contrast-enhanced CT of the pancreas was reported as normal. To overcome this, EUS was performed, successfully identifying a hidden 19 × 18 mm lesion in the head of the pancreas, intimately abutting the main pancreatic duct.

Despite medical therapy with diazoxide and strict dietary modifications, her hypoglycemia remained refractory. Given the tumor's proximity to the main pancreatic duct, surgical enucleation carried a prohibitively high risk of