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.

EP_A123

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

complications. Consequently, she underwent EUS-guided radiofrequency ablation (RFA). Immediate post-procedure outcomes demonstrated near-complete resolution of the hypoglycemic episodes. Diazoxide was subsequently stopped. Outpatient continuous glucose monitoring confirmed sustained normoglycemia and marked symptom resolution, with no procedure-related complications.

CONCLUSION

The absence of a pancreatic lesion on CT demands persistent clinical suspicion in cases of biochemically proven hypoglycemia. EUS remains paramount for detecting occult lesions missed by standard imaging. Importantly, EUS-RFA serves as a highly effective, tissue-sparing alternative to surgical resection for insulinomas, especially when conventional surgery poses prohibitive anatomical risks.

EP_A124

RARE PROGRESSION OF MICROPROLACTINOMA TO MACROPROLACTINOMA: A CASE REPORT

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INTRODUCTION

Prolactinomas are the most common functioning pituitary adenomas, accounting for 50% of all pituitary tumors. Microprolactinomas (<10 mm) are the most frequent subtype and usually follow a benign course, with tumor progression reported in only 5% of cases. We report a rare case of microprolactinoma that progressed to macroprolactinoma over 16 years.

CASE

A 39-year-old female was initially diagnosed with a microprolactinoma at the age of 23 during evaluation for irregular menses since menarche. Baseline pituitary magnetic resonance imaging (MRI) at that time revealed a lesion measuring 2 × 2 × 0.8 mm. She was treated with bromocriptine for 2 months but subsequently lost to follow-up. The patient had been married for 10 years without conceiving and continued to have irregular menses.

She decided to repeat prolactin before seeking fertility treatment after 16 years. Laboratory investigations revealed markedly elevated serum prolactin (>42,000 mIU/L) with suppressed gonadotropins, while thyroid and adrenal axes were normal. She reported no galactorrhea, headache, or visual disturbances and notably did not develop amenorrhea. Visual field assessment was normal.

Repeat pituitary MRI demonstrated that the previously diagnosed microprolactinoma had progressed to a macroprolactinoma, measuring 2.1 × 2.3 × 1.6 cm, with extension into the left cavernous sinus and encasement of the left internal carotid artery, without optic chiasm compression. Oral cabergoline 0.25 mg twice weekly was initiated. She was counselled regarding potential risks of dopamine agonist therapy and advised to use mechanical contraception during treatment. At the 2-week follow-up, she tolerated therapy well. Follow-up imaging and prolactin monitoring were planned at 3 months to assess treatment response and guide fertility planning.

CONCLUSION

This case highlights the rare progression of microprolactinoma to macroprolactinoma, underscoring the importance of long-term monitoring in patients with prolactinoma. A careful balance between tumor control and fertility management is essential for optimizing care in women of reproductive age.

EP_A125

EMPTY SELLA AS A CLUE TO IDIOPATHIC INTRACRANIAL HYPERTENSION PRESENTING WITH PULSATILE TINNITUS AND PROGRESSIVE HEARING LOSS

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INTRODUCTION

Empty sella (ES) is characterized by herniation of the subarachnoid space into the sella turcica, leading to pituitary flattening. Although often considered incidental, ES is increasingly recognized as a radiological marker of idiopathic intracranial hypertension (IIH) which classically presents with headache and visual loss. Importantly, IIH may also present with otolaryngological manifestations such as pulsatile tinnitus, hearing loss, and vertigo. Audiovestibular symptoms have been reported in up to 88.9% of patients with primary ES, with sensorineural hearing loss being the most frequent, while pulsatile tinnitus occurs in approximately 58% of IIH cases.

CASE

A 51-year-old female presented with 3 months of progressively worsening headaches, rapid deterioration of left-sided hearing, and a 20-kg weight gain over 1 year.