

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.

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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.