value, 85.4 nmol/L, after optimization of diabetes. She underwent endoscopic transsphenoidal surgery with normalization of blood sugar post-surgery. Blood pressure was normal throughout.

CONCLUSION

False negative or normal IGF-1 levels may result in patients with hepatic or renal failure, hypothyroidism, malnutrition, use of oral estrogen, severe infection, and poorly controlled diabetes mellitus. Hence, a low or normal IGF-1 does not exclude acromegaly in patients with a high index of suspicion and warrants further investigation.

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BIG AND BLURRY: GIANT PROLACTINOMA CASE SERIES

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INTRODUCTION

Giant prolactinomas represent 2–3% of prolactin-secreting pituitary adenomas and show a male predominance. They present with mass effect symptoms and hypogonadism, but may be overlooked, leading to delayed diagnosis. Although dopamine agonists are first-line therapy, management remains challenging due to the large size and invasive behavior. This study aims to describe the clinical and radiological features, treatment modalities, and outcomes of three cases of giant prolactinomas. We retrospectively reviewed three men with giant prolactinomas, including their clinical, biochemical, and radiological features, along with treatment and outcomes.

CASES

Three male patients aged 35–59 years with giant prolactinomas were included. Two patients presented with visual disturbances, headache, and features of hypogonadism, while one patient had acute confusion and visual loss secondary to obstructive hydrocephalus requiring ventriculoperitoneal shunt insertion. Imaging in all cases demonstrated large invasive pituitary macroadenomas with extensive local extension. Baseline serum prolactin levels were markedly elevated, ranging from 86,568 to 441,116 uIU/mL (86–324 uIU/mL). All patients had secondary hypogonadism, while secondary hypothyroidism and hypocortisolism were each identified in two patients. One patient also had poorly controlled diabetes mellitus at presentation. Dopamine agonist therapy was initiated as the primary therapy for all the patients. Two patients developed cerebrospinal fluid leak following initiation of low-dose dopamine agonist therapy (one patient received cabergoline 0.25 mg weekly, while another received 0.5 mg weekly), which resolved spontaneously with conservative management. Serum prolactin levels decreased markedly, with significant improvement in symptoms related to mass effect following treatment.

CONCLUSION

Giant prolactinomas may present with significant mass effect and multiple pituitary hormone deficiencies. Dopamine agonists remain the cornerstone of management and can result in substantial biochemical and clinical improvement even in large invasive tumors. However, rapid tumor shrinkage may lead to complications such as cerebrospinal fluid leak, highlighting the importance of close monitoring during treatment initiation.

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BEYOND THE INFARCT: THE SILENT SELLAR SURPRISE

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INTRODUCTION

Pituitary apoplexy is a rare, life-threatening endocrine emergency caused by acute hemorrhage or infarction of the pituitary, often in the setting of a pre-existing adenoma (2–12%). While classically presenting with sudden headache, visual loss, and altered consciousness, it can occasionally mimic an acute stroke. Occurrence after coronary procedures is exceptionally rare, particularly when accompanied by cerebral infarction. We report a middle-aged male who developed an acute stroke following percutaneous coronary intervention (PCI) and subsequently had panhypopituitarism secondary to pituitary apoplexy.

CASE

A 50-year-old male, with underlying diabetes mellitus, hypertension, dyslipidemia, and chronic kidney disease stage G3A, initially admitted to a private centre for PCI, however, complicated with acute left-sided weakness, headache, and reduced consciousness 2 days post-procedure. He had a history of progressive left visual loss for 3 months. Examination revealed Glasgow Coma Scale E2V4M4, blood pressure 118/82 mmHg, left-sided power 4/5, and temporal pallor of the left optic disc. His blood sugar was 15.5 mmol/L.