Urgent computer tomography scan of the brain demonstrated a right basal ganglia infarct with sellar mass measuring 15 × 15 × 20 mm extending into the suprasellar cistern with mass effect. Magnetic resonance imaging confirmed multifocal acute and chronic infarcts with an acute pituitary hemorrhage compressing the optic chiasm. Biochemistry showed mild acute kidney injury (urea 11.7 mmol/L, creatinine 119 μmol/L) without electrolyte imbalance, thrombocytopenia, or anemia. Hormonal studies revealed partial hypopituitarism with normal thyroid function, secondary adrenal insufficiency (serum morning cortisol 40 nmol/L), and central hypogonadism (serum testosterone 2.2 nmol/L). Hydrocortisone was initiated inpatient, followed later by testosterone replacement and antiplatelet therapy during follow-up.

CONCLUSION

This case illustrates pituitary apoplexy with an atypical presentation: acute neurological deficits following invasive cardiovascular procedures. It underscores the importance of multidisciplinary management involving endocrinologists, cardiologists, neurologists, and neurosurgeons to optimize outcomes. Early recognition, prompt neuroimaging, and timely treatment are vital to prevent irreversible neurological and endocrine complications.

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AVP DEFICIENCY AS THE INITIAL MANIFESTATION OF MULTISYSTEM LANGERHANS CELL HISTIOCYTOSIS: A DIAGNOSTIC ODYSSEY

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INTRODUCTION

Arginine vasopressin (AVP) deficiency is an uncommon but important presentation of infiltrative hypothalamic–pituitary disorders. In adults, isolated AVP deficiency with pituitary stalk thickening is diagnostically challenging, especially in the absence of systemic disease. Langerhans cell histiocytosis (LCH) is a rare cause and may precede systemic involvement by several years.

CASE

We report a 42-year-old male who presented in 2017 with polyuria and polydipsia, with urine output of up to 10 L/day. AVP deficiency was confirmed by the water deprivation test, and desmopressin was initiated. Initial pituitary magnetic resonance imaging (MRI) was normal, baseline anterior pituitary hormonal evaluation was unremarkable, and contrast-enhanced computed tomography (CECT) of the thorax and abdomen showed no abnormalities.

Repeat pituitary MRI 1 year later demonstrated loss of the posterior pituitary bright spot with pituitary stalk thickening. In the absence of systemic involvement, a presumptive diagnosis of lymphocytic hypophysitis was made, and pituitary biopsy was deferred due to the high procedural risk.

Serial pituitary MRIs over the following years showed persistent infundibular thickening and continued absence of the posterior pituitary bright spot, without interval progression or development of additional hormonal deficiencies. The patient remained clinically stable until June 2024, when new-onset left hip pain prompted MRI, revealing a heterogeneous mass involving the femoral neck and intertrochanteric region with a pathological fracture. Histopathological examination following wide resection confirmed LCH, with negative BRAF V600 mutation. Postoperative PET scan revealed a multisystem disease involving the skeleton, lymph nodes, spine, and gastrointestinal tract, with no bone marrow involvement. He subsequently completed six cycles of intravenous methotrexate and cytarabine.

CONCLUSION

Adult-onset AVP deficiency may be the earliest manifestation of occult multisystem Langerhans cell histiocytosis. This case highlights the importance of long-term follow-up and reconsideration of the initial diagnosis when new systemic features emerge.

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A RARE CASE OF PITUITARY APOPLEXY ASSOCIATED WITH MIDDLE CEREBRAL ARTERY INFARCT: A CORRELATION OR COINCIDENCE?

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INTRODUCTION

Pituitary apoplexy is a rare, life-threatening condition resulting from hemorrhage or infarction of the pituitary gland, most commonly in patients with pre-existing pituitary tumors. It typically presents with a sudden headache, visual disturbance, ophthalmoplegia, and altered mental status. An uncommon but serious complication is ischemic stroke in the middle cerebral artery (MCA)