territory, particularly in the absence of direct internal carotid artery (ICA) compression.

CASE

We report a case of a 36-year-old male who presented with headache, visual impairment, and fever. Initial computed tomography (CT) brain imaging demonstrated a heterogeneous sellar lesion with peripheral calcification measuring 2.4 × 3.2 × 2.7 cm, suggestive of a pituitary mass with possible apoplexy, without evidence of acute cerebral infarction. The patient subsequently developed dysarthria, hemianopia, and reduced consciousness, prompting repeat neuroimaging. Follow-up CT revealed a large hypodense area in the right fronto-parieto-temporal region consistent with ischemic infarction. Magnetic resonance imaging confirmed an acute infarct in the right MCA territory without hemorrhagic transformation. A sellar-suprasellar mass measuring 2.3 × 2.8 × 3.8 cm was identified, consistent with a pituitary macroadenoma with intratumoral hemorrhage compressing the optic chiasm, but without direct right ICA compression. Time-of-flight mineralocorticoid receptor antagonists demonstrated attenuated flow in the right ICA (C2–C7), suggesting intracranial ICA thrombosis and reduced perfusion in the right MCA and its branches. Laboratory evaluation revealed hyperthyroidism and hypocortisolism, with no evidence of coagulopathy. The patient was treated with corticosteroid replacement and carbimazole and referred for neurosurgical management.

CONCLUSION

This case highlights a rare association between pituitary apoplexy and MCA stroke, possibly mediated by vasospasm, inflammation, or hypercoagulability. More research is needed to understand this connection and improve treatment strategies.

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DEFYING THE SCALPEL: MANAGEMENT OF PITUITARY APOPLEXY WITH HYDROCORTISONE

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INTRODUCTION

Pituitary apoplexy is an acute endocrine emergency, as early recognition may influence the outcomes, often presenting with sudden headache, visual disturbances, ocular palsies, vomiting, or altered consciousness. Given that urgent surgical decompression is a common management, emerging evidence supports corticosteroid therapy in our patient with significant neuro-ophthalmic deficits.

CASE

A 65-year-old male with hypertension, dyslipidemia, type 2 diabetes mellitus, chronic kidney disease stage III, and ischemic heart disease presented with a 4-day history of fever, vomiting, bifrontal headache, and generalized abdominal pain. Initially, he was treated for presumed intra-abdominal sepsis. On day 3 of admission, he developed acute right-sided complete ptosis with ophthalmoplegia involving cranial nerves III, IV, and VI. Prior to that, he had also reduced morning erections for 6 months before presentation. Biochemical evaluation revealed markedly reduced total testosterone (0.33 nmol/L) with inappropriately low–normal gonadotropins (luteinizing hormone 1.5 IU/L, follicle-stimulating hormone 2.3 IU/L), in keeping with secondary hypogonadism. Adrenocorticotropic hormone was suppressed, indicating secondary adrenal insufficiency. Thyroid function was preserved. Overall findings suggested partial hypopituitarism. Magnetic resonance imaging confirmed a cystic pituitary lesion measuring 1.4 × 2.6 × 1.8 cm with cavernous sinus involvement and features of pituitary apoplexy. His Pituitary Apoplexy Score was 4. He was offered surgical intervention but was not keen. He was treated with intravenous hydrocortisone, with rapid clinical improvement, including near-complete resolution of right eye ptosis and restoration of extraocular movements within 3 days, and was able to recover without surgery. The hydrocortisone was gradually tapered, and the patient was discharged well with Endocrine follow-up.

CONCLUSION

Timely corticosteroid therapy alone can result in rapid, near-complete neurological recovery in pituitary apoplexy, even with multiple cranial nerves involvement. In carefully selected patients without visual field compromise, conservative management may safely obviate the need for urgent surgical intervention, emphasizing the importance of early recognition and individualized treatment strategies.