



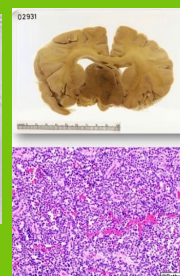
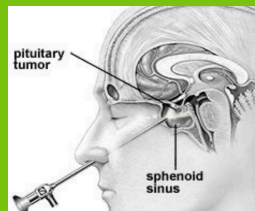
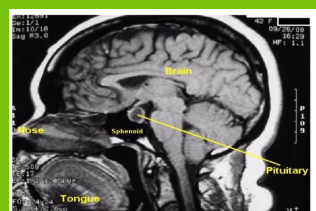
Rare Case of Successful Pregnancy Outcome in Acromegalic Female with Pituitary Adenoma following Transphenoidal Pituitary Adenectomy: Case Report & Literature Review

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Introduction

Acromegaly is a rare clinical disorder in which there is progressive somatic disfigurement and a wide spectrum of systemic complications which include gonadotrophic dysfunction, menstrual irregularities and infertility. Pregnancy in patients with acromegaly is a rare condition. Pituitary adenomas are common pituitary tumors, these are functioning and non-functioning. 75% pituitary adenomas are endocrinologically active. Few cases of successful pregnancy are recorded in patients with acromegaly due to pituitary adenomas. We report a case of acromegalic subfertile female with pituitary macroadenoma and hyperprolactinemia who had successful pregnancy outcome after transphenoidal pituitary adenectomy.



Case Report

26yrs old female presented in GOPD with history of primary subfertility from last 6 years, enlargement of hands, feet and skin tags formation for 4 years. There was also Hx of menstrual irregularities. Clinical examination revealed young female, well oriented in time, place & person. Her height 5-8, she had markedly enlarged hands and feet. Her systemic and pelvic examination was normal. On investigation her GH level was 108 (N-14 mIU). S. Prolactin was 804 ng/ml (N 3.8-208 ng/ml). Her Gonadotrophin and Cortisol levels were normal. MRI Brain showed well defined lobulated sellar mass lesion measuring 2.3x2.0x1.8 cm, predominantly involving right side of pituitary gland causing expansion of sella, deviation of pituitary stalk towards left side and encasement of right cavernous sinus, suggestive of Pituitary adenoma.

Contd.

Patient was referred to Neurosurgeon, she underwent TSPA. Histopathology report showed benign pituitary adenoma, composed of monomorphic cells having round to oval nuclei and acidophilic cytoplasm. No nuclear atypia or mitosis. After surgery patient regularly took Bromocriptine. Later she presented in Antenatal clinic after spontaneous conception. During pregnancy she developed Preeclampsia and underwent LSCS at 33 weeks. Outcome was alive female baby with good APGAR score.

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Discussion

Prolactinomas are the most common neoplasm of the anterior pituitary gland. Treatment of hyperprolactinemia is indicated because of resulting infertility, gonadal dysfunction and osteoporosis. Macroprolactinomas are less common than microprolactinomas in females. In macroprolactinomas, symptomatic tumor enlargement occurs in 20-30% of cases. It is reported that the risk of clinically significant tumor enlargement reduces to from 30% to <5% if the patient is treated with radiation or surgery before pregnancy.

Acromegaly is a disease diagnosed with increasing frequency in child-bearing age of women. Treatment options for acromegaly include surgery, medical management and in some cases radiotherapy. These therapeutic modalities control tumor growth and reduce the clinical consequences of hypersomatotropism in patients. Bromocriptine is the first drug of choice and it reduces the tumor size and eliminates symptoms. Cabergoline is another option if the adenoma does not respond to bromocriptine. If tumor does not respond to Cabergoline, then alternative is transsphenoidal surgery. Patients with macroprolactinomas and extrasellar extensions are prohibited from conceiving until definitive therapy. Surgical debulking may be considered prior to pregnancy, as surgery or radiation decreases symptomatic tumor enlargement but there is associated high risk of hypopituitarism in these cases.

Endonasal transsphenoidal resection is a safe, well-tolerated treatment option for pituitary adenomas. Macroadenomas can be managed with minimal morbidity. Pituitary endocrine function is usually preserved, and most of patients will not require long-term medical treatment.

References

1. A Abreu & A Rueda. Acromegaly and Pregnancy. case reports. Endocrine Abstracts (2012) 29 P1487
2. Fernandez A, Noval S, De La Calle M, Alvarez MP, Escala CA. Management of acromegaly in pregnancy: case reports and literature review

