References

The Occurrence of Lymphocytic Hypophysitis in a First but Not Subsequent Pregnancy

To the editor:

Despite a number of reports of lymphocytic hypophysitis in the last year, the natural history of this disorder remains unclear (1–3). It appears that in most cases permanent partial or panhypopituitarism ensues, although there have been a few reports including that by Hughes et al. in the May 1995 issue of JCEM (1) of complete recovery of pituitary function. In those cases where gonadal function has been restored, no subsequent pregnancies have been documented. It has therefore been impossible to determine the impact of a history of lymphocytic hypophysitis on the course and outcome of any subsequent pregnancy. We report a case of lymphocytic hypophysitis where recovery of gonadal function was followed by an uncomplicated pregnancy, the first such case to be reported in the literature.

A 34-yr-old woman presented with fatigue, myalgia, secondary amenorrhea, and dyspareunia 4 months after the birth of her first child. She had had an uncomplicated pregnancy without headache or visual disturbance and had delivered a healthy female infant. Post-partum however, lactation was not established. On physical examination she appeared pale. The blood pressure was 110/75 mmHg lying and 100/70 mmHg standing. There was no galactorrhea. She had normal axillary and pubic hair. Visual fields were full to confrontation and funduscopic examination was normal. The relaxation phase of the deep tendon reflexes appeared delayed.

Hormonal evaluation revealed panhypopituitarism with a free T4 of 5.7 pmol/L (ref range 9–20.6), TSH 1.28 mIU/L (0.15–3.2), oestradiol 55 pmol/L (>110), LH 2.1 U/L (2–11), FSH less than 1 U/L (2–11), PRL 11 mIU/L (7–20), GHR less than 1 mU/L, and morning cortisol of 201 nmol/L (165–772). Following administration of 2 g metyrapone there was an inadequate 11-deoxycortisol response of 24 nmol/L (>200) despite adequate suppression of cortisol levels to 117 nmol/L. A computed tomography (CT) scan demonstrated a 15 mm pituitary mass with suprasellar extension, which showed uniform enhancement following administration of contrast (Fig. 1).

Given the absence of visual field impairment, it was decided to manage the patient conservatively, and replacement with L-thyroxine, 0.1 mg daily and hydrocortisone 20 mg was instituted. Over the next few months regular menstruation resumed, and oest

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FIG. 1. Post contrast CT scan of the pituitary at initial presentation, demonstrating a large pituitary mass with suprasellar extension.

FIG. 2. Post contrast CT scan of the pituitary 6 months later showing a normal pituitary gland.

drotriol levels returned to the normal range. The patient continued to require adrenal and thyroid hormone replacement therapy. A repeat CT scan 6 months after the initial presentation showed complete resolution of the pituitary mass (Fig. 2).

The patient subsequently became pregnant on three occasions. The first two pregnancies ended in spontaneous abortion, but the third pregnancy was carried to term resulting in the birth of a healthy female infant. During this pregnancy visual fields remained normal, and no adjustment was required in the patient's replacement therapy. A CT scan 3 months post-partum showed no recurrence of the pituitary mass.
While a tissue diagnosis was not obtained in this patient, it was felt that the clinical setting of post-partum hypopituitarism associated with a resolving pituitary mass that showed uniform contrast enhancement on CT scanning was classic for lymphocytic hypophysitis (2). As Hughes et al. (1) point out, current opinion now favors conservative management in patients with suspected hypophysitis unless optic nerve compression is present.

Under these circumstances it was felt that submitting this patient to surgical biopsy was not justified. This report describes a second uncomplicated pregnancy in a woman with a history highly suggestive of lymphocytic hypophysitis, illustrating that the inflammatory process does not inevitably recur in association with each pregnancy.

References