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# Lymphocytic and Granulomatous Hypophysitis: Experience with Nine Cases [Correspondence]

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To the Editor:

Mueller et al. (2) describe in their letter a case of granulomatous hypophysitis of unknown etiology. The patient was a 15-year-old girl presenting with aseptic meningitis. She had had recurrent episodes of fever and had developed secondary amenorrhea and diabetes insipidus. Magnetic resonance imaging (MRI) revealed a sellar lesion extending to the suprasellar area and a pituitary stalk enlargement.

Pituitary inflammatory diseases are generally misinterpreted preoperatively as pituitary adenomas because of the rarity of these lesions in contrast to the frequency of pituitary adenomas. Honegger et al. (1) reported six cases of lymphocytic hypophysitis and three cases of idiopathic granulomatous hypophysitis in more than 2362 operations for pituitary lesions. Radiological differential diagnostic criteria are not well established. However, there are some suggestive symptoms and signs of hypophysitis. One of them is diabetes insipidus, which is unusual for pituitary adenomas. Sudden onset of visual disturbances, headache, nausea, and vomiting can also occur in cases of hypophysitis; but in cases of pituitary adenomas, these symptoms indicate intratumoral hemorrhage, which can easily be detected by neuroradiological examinations. Nevertheless, some patients with granulomatous hypophysitis present with amenorrhea only.

The authors examined the patient carefully and suspected pituitary inflammation. However, neither their reason for preferring the transcranial approach instead of the transsphenoidal route nor their surgical aim (biopsy or total resection) is clear from their report. It is generally accepted that the majority of pituitary adenomas, even if they have suprasellar extension, can be resected by the transsphenoidal route unless the extension is asymmetric. Mueller et al. did not describe the type of suprasellar extension nor their surgical findings.

Recent reports favor biopsy for lesions suspected to be hypophysitis, because these lesions are so firm that aggressive resection causes impairment of endocrine function (3-5). The good response to corticosteroid therapy mentioned by Mueller et al. is generally accepted (1, 3, 4). In addition, aseptic meningitis was reported in 1997 by Vasile et al. (5) in a 40-year-old woman with idiopathic granulomatous hypophysitis; this report was not mentioned by Mueller et al. It must be emphasized that if a pituitary inflammatory lesion is suspected, histopathological confirmation by transsphenoidal biopsy, followed by corticosteroid therapy, is considered the best treatment protocol.

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