

Certainly, other sources of the fungus are possibilities and the authors postulate that a wick of anterior capsule in the wound probably acted as a nidus and a portal of entry. In any case early diagnosis with persistent and sustained antifungal therapy resulted in an extremely favourable outcome.

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Sir,

Incomplete bitemporal hemianopia without headache: an unusual case of pituitary apoplexy

Pituitary apoplexy is a well described but uncommon clinical syndrome resulting from a sudden enlargement

of a pituitary adenoma due to haemorrhage or infarction. Usually, pituitary apoplexy is accompanied by the sudden onset of headache with meningeal irritation, and frequently followed by visual impairment and ophthalmoplegia.^{1–4} However, these symptoms may not be present and therefore misdiagnosis of the disease frequently occurs. Such a delay in diagnosis may lead to visual impairment because an early diagnosis and subsequently surgical decompression of the sellar region within a few days of apoplexy is of major importance in restoring vision and severe pituitary failure.^{5–7}

Here we report a patient with an unusual presentation of pituitary apoplexy without headache or other general symptoms. The visual field deficit in both eyes was characterised as being chiasmatic and the CT scan led us to the correct diagnosis within 4 h.

Case report

An otherwise healthy 27-year-old man was referred to our hospital because of the acute onset of blurred vision. He denied any headache or double vision. He also denied any neurological or endocrinological symptoms. Ophthalmic examination showed a visual acuity of 20/20 in the right eye and 20/600 in the left. There was no improvement with pinhole. Ocular motility examination was normal. No intraocular abnormalities were seen in either eye and there was no relative afferent pupillary defect. Perimetry showed incomplete bitemporal hemianopia (Fig. 1). A cerebral CT scan was immediately done and showed a sellar tumour with hypodense areas as a sign of a haematoma (Fig. 2). Based on these findings the diagnosis of pituitary apoplexy was made and transsphenoidal decompression of the sellar region was performed 16 h after the patient had initially experienced blurred vision. Surgery was performed without any intraoperative complications. On the first post-operative day visual acuity in the left eye improved to 20/30 and in neither eye was any visual field defect noted (Fig. 3).

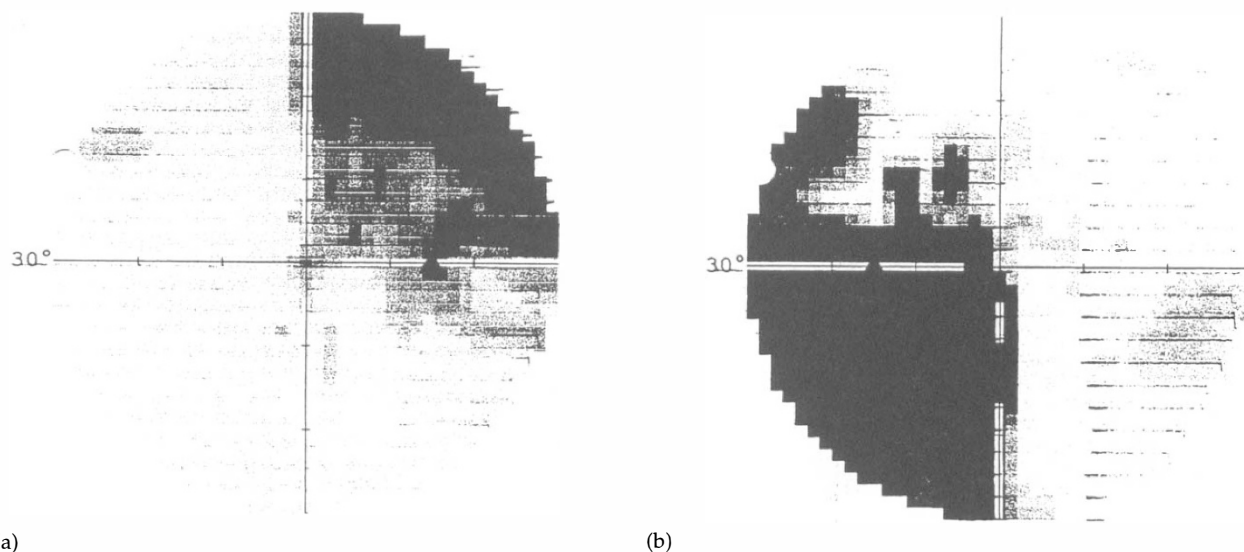


Fig. 1. Visual field before surgery showing an incomplete bitemporal hemianopia. (a) Right eye; (b) left eye.

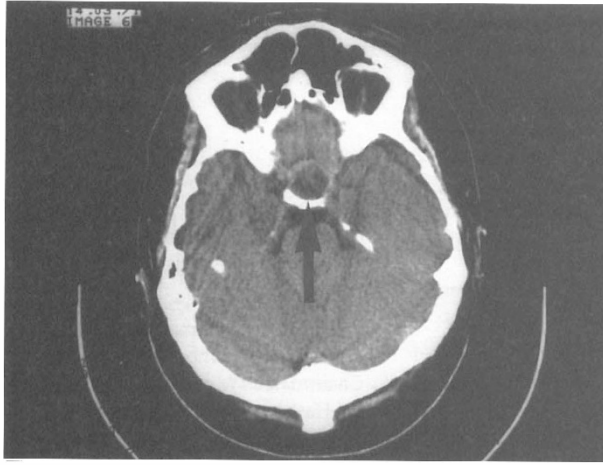


Fig. 2. CT scan showing pituitary adenoma with haemorrhage (arrowed).

Comment

The incidence of pituitary adenoma is around 15% of all symptomatic intracranial neoplasms. Although uncommon before the age of 20 years, their incidence increases with age after the fourth decade of life. Autopsy studies have shown that the prevalence of asymptomatic pituitary adenomas may be as high as 27% and that adenomatous hyperplasia may be found in almost every pituitary gland.⁸ Pituitary apoplexy is a rare complication of pituitary adenoma with a frequency between 0.6% and 10% of operated adenomas.^{6,9} The classical clinical appearance of pituitary apoplexy with the sudden onset of headache, often accompanied by vomiting and signs of meningitis, is well recognised, but not always present. Therefore, misdiagnosis of apoplexy is not uncommon. A further cause for confusion is the absence of clinical features of an endocrinological disorder.^{3,4}

Visual impairments are very common at clinical onset and are the most important clinical features of pituitary apoplexy. Depending on the location these visual impairments are shown as a visual field defect that characterises the lesion as being chiasmatic if the growth of the pituitary mass is superior or as ocular motility defects due to inferior growth and cavernous sinus compression.⁴ Therefore, for the correct diagnosis a careful demonstration of a visual field deficit related to

the sellar region or abnormalities in ocular motility is of critical importance. A following CT scan permits the diagnosis of pituitary apoplexy.¹⁰

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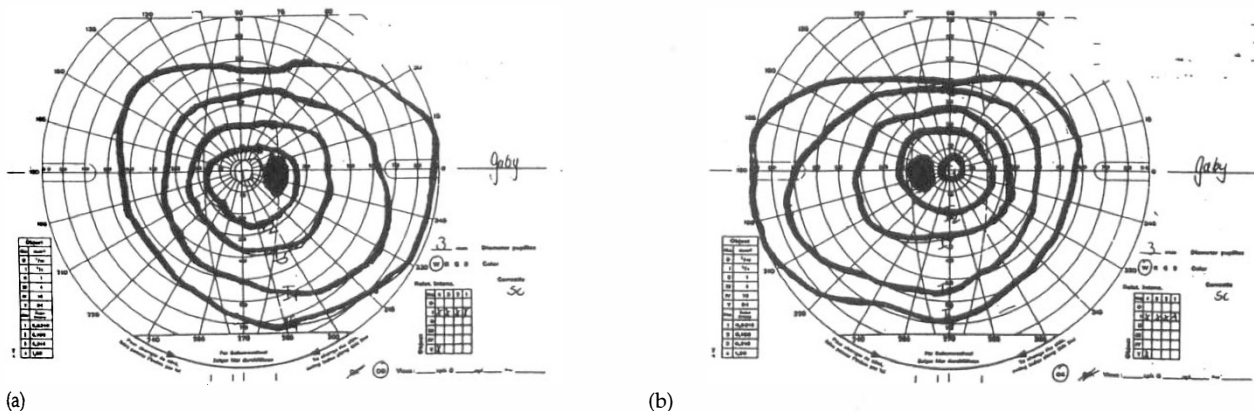


Fig. 3. Visual field 1 day after decompression of the sellar region. No visual field defect was noted. (a) Right eye; (b) left eye.