Original Research Paper

Volume-9 | Issue-5 | May-2019 | PRINT ISSN No 2249 - 555X

Neurosurgery

A CASE OF SELLAR HAEMATOMA WITHOUT PREEXISTING ADENOMA - CASE REPORT

Saurav kumar	Resident
Anand prakash *	Associate Professor Department of neurosurgery , Rajendra Institute Of Medical Sciences, Ranchi ,jharkhand, India,pin-834009 *Corresponding Author
C b sahay	Professor
Prof. Anil Kumar	Professor

ABSTRACT Pituitary tumours have varied presentation,most commonly manifesting as visual deficits, headache, and various endocrinal abnormalities. These are attributed to compression of the fibres of the optic nerve, stretching of the sellar diaphragm and impairment of hormonal release signals from the hypothalamus. But presentations of a pituitary lesion with spontaneous haemorrhage is less common , and sellar haematoma in the absence of any preexisting lesion is rare. A case of sellar haematoma in young boy is presented here,without any evidence of any prior pathology.

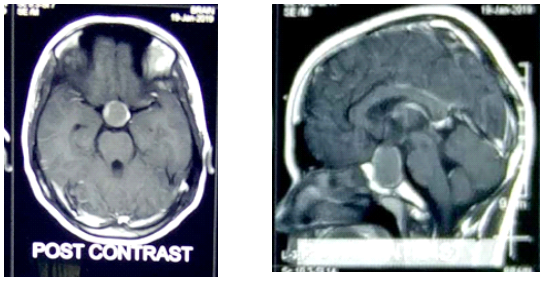
KEYWORDS : pituitary,visual,sella

INTRODUCTION

Pituitary tumours have varied presentation,most commonly manifesting as visual deficits, headache, and various endocrinal abnormalities. These are attributed to compression of the fibres of the optic nerve, stretching of the sellar diaphragm and impairment of hormonal release signals from the hypothalamus. But presentations of a pituitary lesion with spontaneous haemorrhage is less common , and sellar haematoma in the absence of any preexisting lesion is rare.[1] A case of sellar haematoma in young boy is presented here,without any evidence of any prior pathology.

CASE REPORT

A young male , 17 years of age came to us with complains of headache and visual blurriness in both eyes for the last 1 month. His visual fields were normal. On imaging, MRI brain T1W1 revealed isointense cystic lesion in the sella with peripheral uptake of contrast , with clear fluid level and T2W images confirmed the findings with partly hyperintense and partly hypointense lesion with clear demarcation between the two suggestive of a fluid level.[Figure 1,a,b and 2]



1.MRI BRAIN WITH CONTRAST revealing sellar space occupying lesion isointense on T1W images
Fig. (a) axial cuts(b) sagittal cuts

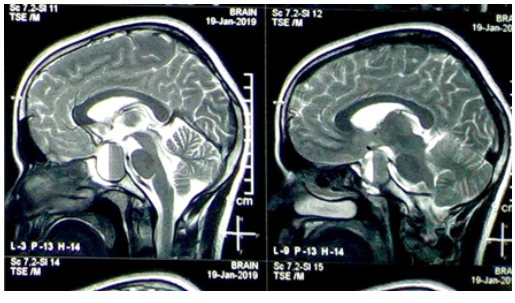


Figure2.MRI BRAIN T2W images showing sellar lesion with partially hypointense and partly hyperintensity, with fluid level

CT SCAN of the PARANASAL sinus revelaed poorly pneumatised sphenoid sinus.[figure 3]

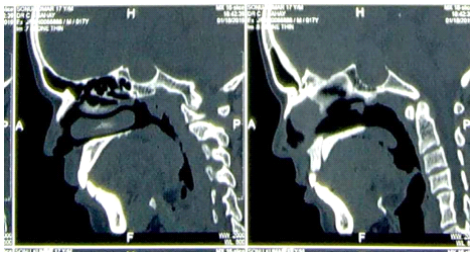


Figure 3. . CT skull sagittal cuts showing poorly pneumatised sphenoid sinus

His endocrinal work up did not reveal any hormonal imbalance except for raised serum prolactin levels that was around 112 ng /ml. The patient was counselled and advised surgery.

The operation was carried out using the Endoscopic transnasal transphenoidal approach . As the sphenoid sinus was poorly pneumatised , it had to be drilled all along to reach the sellar floor. The floor was found to be bulging. On opening the sellar floor with cruciate incision, yellowish xanthochromic fluid followed by liquefied clot came out and the sellar roof sagged with normal pituitary being visible . No other pathology could be identified .[Figure 4]

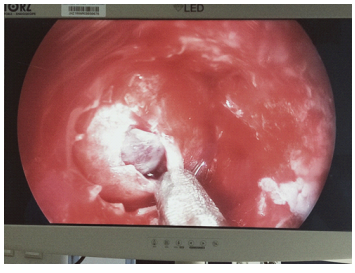


Figure 4.intraoperative picture showing sagging sellar diaphargm after haematoma evacuation, not associated with any adenoma like lesion

The floor was repaired with fat graft and glue. Postoperatively , the headache was relieved and vision improved to normal on the 2nd day.

DISCUSSION

Pituitary apolplexy is an endocrinal emergency due to sudden haemorrhage and infarction of pituitary tumour, commonly into a preexisting tumour,most likely an adenoma.[2] Factors such as hypertension , coagulopathies, drugs and radiation predispose to such

events and pregnancy is a condition known to be associated with this. Common presentation include severe headache,visual defects, hypopituitarism and altered sensorium.[3]

However , presentations of pure sellar haematoma , not associated with pituitary adenomas in a young male is rarely encountered ,Saito et al reporting a similar case, and hence must be considered as differential of such lesions.[4]

REFERENCES

1. Fraioli, B., Esposito, V., Palma, L., & Cantore, G. (1990). Hemorrhagic pituitary adenomas: Clinicopathological features and surgical treatment. Neurosurgery, 27(5), 741-748.
2. Dunn PJ, Donald RA, Espiner EA (1975) Regression of acromegaly following pituitary apoplexy. Aust NZJ Med 5: 369–372
3. Lloyd MH, Belchetz PE (1977) The clinical features and management of pituitary apoplexy. Postgrad Med J 53: 82–85
4. Saito, K., Takayasu, M., Akabane, A. et al. Acta neurochir (1992) 114: 147. https://doi.org/10.1007/BF01400605