LT was lost to follow-up for 6 years. At 11 years old, LT had been consistently raised as a female. When asked about gender identity, LT's understanding of gender identity developed over time. At 11 years old, LT declared her gender identity as a "boy", because boys are "strong", and because she did not like make-up. LT denied any desire for breast development and explained that her family told her that breasts 'make it hard to run fast.'

On follow-up evaluation 6 months later, LT voiced her decision to be a girl, and said that she was very confident in this decision. LT and her parents both desired estrogen therapy for induction of puberty. After discussions regarding the permanent effects of therapy, LT started hormone therapy. Two months after initiation of therapy, she remained firm in her gender identity and expressed a desire to grow her hair long. She independently stated that she did not desire surgery at this time. She will receive formal psychological testing at her next clinical evaluation to evaluate her for body dysmorphia, anxiety, and depression.

Discussion

LT's case demonstrates the progression of developmental understanding of gender and expressed gender identity that may occur as learning progresses in patients with DSDs. This case also shows that a delay in surgery may not have significant developmental consequences to these patients as was previously suggested. In general, the American medical system has tended to perform early sex assignments and surgical interventions to align anatomy with the sex assignment. However, after thoughtful discussions regarding human rights concerns, many have recommended to delay surgical interventions until adolescence, when the patient can consent appropriately to interventions that cause permanent anatomic changes. As many of these interventions may be discussed in early adolescence, it is of the utmost importance that information is presented in an understandable and developmentally appropriate manner.

Neuroendocrinology and Pituitary

CASE REPORTS IN CLASSICAL AND UNUSUAL CAUSES OF HYPOPITUITARISM II

Mycobacterium Fortuitum Infection Mimicking Sellar Chondrosarcoma in a Non-Immunosuppressed Patient: An Unusual Cause of Hypopituitarism and Oculomotor Nerve Palsy

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A 32-year old male patient of central African origin presented with diplopia and left eyelid ptosis. He described a 2-month history of fatigue, weight loss (8 Kg), headaches, diffuse myalgia and night sweats. Clinical examination revealed cavernous sinus syndrome with left eyelid ptosis and weakness of eye adduction. Magnetic resonance imaging of the brain demonstrated a 36 mm mass centered on the left petroclival suture, infiltrating the sella and the pituitary gland, the ipsilateral orbital apex as well as the cavernous sinus bilaterally. The mass showed heterogenous enhancement after gadolinium injection, with elements of central necrosis and was associated with an extensive bone destruction. These radiologic features raised the hypothesis of chondrosarcoma. Chest computed tomography demonstrated multiple lung micro-nodules suspect of metastasis. Laboratory testing of the anterior pituitary function revealed low free-T4 (11 pmol/l, n = 12-22) with normal TSH (0.4 mUI/l, n=0.3-4.2), low total testosterone (1.5 ugr/l, n = 3.3-8.1) with normal LH and FSH and slight hyperprolactinemia (27 ugr/l, n = 4-15). IGF-1, 24-h urinary free cortisol, as well as morning serum cortisol and cortisol after 250 mcg ACTH stimulation test were normal. There was no evidence of diabetes insipidus. Levothyroxine was prescribed. Craniotomy was performed, for left optic nerve decompression and biopsy of the mass. Pathologic examination revealed granulomatous, giganto-cellular and necrotizing inflammation, but no evidence of malignancy. PCR for Mycobacterium tuberculosis complex was negative but Mycobacterium fortuitum was detected in sputum and also confirmed in cerebral biopsy latter. Other causes of granuloma were excluded (brucellosis, cat scratch disease, histoplasmosis, syphilis, coccidioidomycosis, tropical germs etc.). Different causes of immunosuppression (including HIV) were excluded. The patient was treated with amikacin, isoniazid and ciprofloxacin for several months and improved gradually. MRI performed one year later demonstrated significant decrease on the size of the sellar mass (more than 50% of its initial size). Central hypogonadism regressed spontaneously with decrease in tumor size, and normal testosterone levels were achieved at one-year follow-up (7 ugr/l, n = 3.3-8.1). Mycobacterium fortuitum infections of the sella turcica are poorly described in literature in non-immunosuppressed individuals. Although usually not pathogenic, histopathological examination, identification in the CNS lesion and the lungs and response to treatment are convincing evidence of a causal relationship. Differential diagnosis from malignant lesions is challenging and biopsy is necessary in order to establish the cause and offer adequate treatment.

Bone and Mineral Metabolism

OSTEOPOROSIS: DIAGNOSIS AND CLINICAL ASPECTS

Efficacy of Low Dose Denosumab in Maintaining Bone Mineral Density in Postmenopausal Women with Osteoporosis: A Real World, Prospective Observational Study

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Introduction: Denosumab, a fully human monoclonal antibody to RANK-ligand, has been shown to increase bone mineral density (BMD) and reduce the risk of hip, vertebral