extend. First, most of the described points in conclusion such as short lag time, diabetes insipidus (DI), rapidly appearing sellar mass, etc., can occur in adenomas with hemorrhage, cysts, hypophysitis, and pseudotumours which are much common than pituitary metastasis (PM).[2-4] Second, metastases can occur in preexisting adenomas leading to a sudden increase in the size of tumor.[5] Though PM tends to involve neurohypophysis earlier than adenohypophysis, only one case had preoperative DI and two cases had postoperative DI, which can occur as a complication of any hypophyseal surgery. Third, another differential diagnosis in the first two cases can be the rarely encountered pituitary carcinoma.[6] As seen in the second case, PM is highly unlikely given the gland size and accessibility for a distant primary to metastasize. Fourth, what were the exact histopathological findings and was any immunohistochemistry done to strengthen the diagnosis of PM? Occassionally, the Ki-67 proliferation index and electron microscopic ultrastructural features matched between PM and primary are useful to have definitive diagnosis and prognostication.[7] The histopathological features alone may not be sufficient to differentiate between adenoma, carcinoma, and PM. Fifth, the isolated presentation of a systemic malignancy with PM could be due to referral bias or chronology of clinical documentation, as such cases are anecdotal to the best of our knowledge.

Last, we have to be very critical in labeling a case as PM as clinically, radiologically, and biochemically, the overlap with other pituitary pathologies is significant and the prognostic difference is significant.

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Pituitary metastasis as a presenting manifestation of silent systemic malignancy: A retrospective analysis of four cases

Sir,

It is an informative and a well-drafted attempt to take an endocrinological view of pituitary metastases from a distant primary.[1] But, I have few queries and observations to

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