

hypotension preceded by a 6 month history of intense fatigue. She did not take any steroids in the 6 months prior. Initial tests were consistent with secondary adrenal insufficiency; low plasma cortisol (<1ug/dl n 5-23 ug/dl) and ACTH-concentrations below detection (< 4 ng/l), central hypothyroidism; abnormal low TSH (0.04uU/ml n 0.4-4.5 uU/ml) and low free T4 (0.56 ng/dl n 0.8-2 ng/dl), and growth hormone deficiency (IGF1 below age and sex normal values). Cranial CT and pituitary MRI didn't show any anomaly. Based on symptoms, clinical context and test results the presumptive diagnosis was AH related to her lupus. The patient was treated with hydrocortisone and levothyroxine with excellent response and complete resolution of her symptoms. Clinical Lesson: This case demonstrates that hypophysitis is a clinical entity that can be suspected and treated based on clinical and past medical history even in the context of normal imaging were an invasive procedure such as a biopsy would likely not change the final outcome.

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Autoimmune Hypophysitis: Diagnosis Beyond Imaging

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Background: Lymphocytic (LH) or autoimmune hypophysitis (AH) is a rare inflammatory disorder of the hypophysial gland, often miss-diagnosed. LH is predominant in females, occasionally related with other rheumatic disorders (1-20%). The disease can lead to pituitary dysfunction and symptoms of hypopituitarism, the most affected axes are the ACTH and TSH. Definitive diagnosis of AH can be based only on pathological examination of a pituitary biopsy sample but such invasive procedure is seldom needed. Different imaging modalities, especially MRI, can be useful but up to 30% can be unremarkable, thus clinical manifestations and biochemical evaluation is of great importance in guiding the diagnosis. Hormonal replacement therapy is the main treatment strategy. Immunosuppressive drugs are indicated by the severity of the symptoms and the underlying autoimmune disease. **Clinical Case:** A 36 year old patient with active lupus and Sjogren disease presented to the emergency department with syncope and