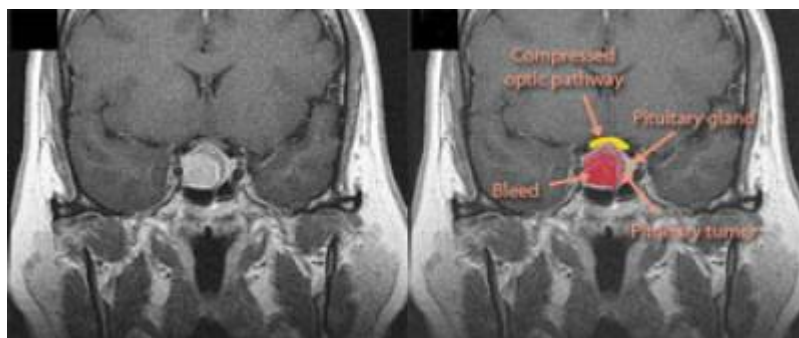


Pituitary apoplexy treatment



- Association of non-English language preference with tumor characteristics and postoperative outcomes following pituitary neuroendocrine tumor resection: a retrospective review of 1143 cases
- Pituitary Apoplexy in a Child with Short Stature and Possible Recent SARS-CoV-2 Infection
- Pituitary apoplexy: surgical or conservative? A meta-analytical insight
- Pituitary Apoplexy Following Gonadotropin-Releasing Hormone Agonist Therapy: A Rare and Life-Threatening Complication
- Long-term pituitary function following transsphenoidal surgery for non-functional pituitary neuroendocrine tumor with apoplexy: a single-center retrospective analysis
- Septicemia following sudden pituitary apoplexy after bladder tumor surgery: a case report
- Pituitary apoplexy in the setting of severe headache and unconsciousness
- Pituitary apoplexy in a patient on antiplatelet therapy: A case report

Pituitary apoplexy is a challenging condition due to its variable course, its diagnosis difficulty, and management, as gaps remain to determine the best approach to treat this condition ¹⁾

The pituitary function is consistently compromised, necessitating rapid administration of **corticosteroids** and endocrine evaluation.

Patients with **pituitary apoplexy** may have a spontaneous remission of hormonal hypersecretion. If it is not an emergency, we should delay a decision to undertake surgery following **apoplexy** and re-evaluate hormone secretion. **Hyponatremia** is an acute sign of **hypocortisolism** in pituitary apoplexy. However, **SIADH** although uncommon, could appear later as a consequence of direct **hypothalamic** insult and requires active and individualized treatment. For this reason, closely monitoring **sodium** at the beginning of the episode and throughout the first week is advisable to guard against SIADH. Despite being less frequent, if **pituitary apoplexy** is limited to the tumor, the patient can recover pituitary function previously damaged by the undiagnosed **macroadenoma** ²⁾.

In the absence of **visual deficits**, **lactotroph adenomas** may be treated with **bromocriptine**.

Rapid decompression is required for: sudden constriction of **visual fields**, severe and/or rapid

deterioration of acuity, or neurologic deterioration due to [hydrocephalus](#). Surgery in ≤ 7 days of pituitary apoplexy resulted in better improvement in [ophthalmoplegia](#) (100%), [visual acuity](#) (88%) and field cuts (95%) than surgery after 7 days, based on a retrospective study of 37 patients.³⁾

Decompression is usually via a transsphenoidal route (transcranial approach may be advantageous in some cases).

A systematic literature search was performed of [MedLine](#), [Embase](#), the [Cochrane Library](#), and the [Web of Science](#) for articles published between January 1992 and September 2014. Studies of the outcomes in consecutive patients that compared surgical intervention with non-surgical treatment for pituitary apoplexy were included.

Six studies met the inclusion criteria. As compared to the non-surgically treated patients, surgically treated patients had a significantly higher rate of recovery of ocular palsy and visual field (both $P < 0.05$). However, there was no significant difference in the recovery of visual acuity and pituitary function ($P > 0.05$) between the two groups.

The findings of this study suggest that surgical intervention should be advocated for pituitary apoplexy patients with visual field defects and ocular palsy⁴⁾.

Goals of surgery

1. To decompress the following structures if under pressure: optic apparatus, [pituitary gland](#), [cavernous sinus](#), [third ventricle](#) (relieving [hydrocephalus](#))
2. Obtain tissue for pathology
3. Complete removal of the tumor is usually not necessary
4. For hydrocephalus: [ventricular drainage](#) is generally required.

References

1)

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