CASE #2

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Cushing's syndrome was diagnosed in a 36-year-old man in 1957 following which 3,000 rads were applied to the pituitary gland without relief of symptoms. In October, 1958, he underwent subtotal adrenalectomy (for adrenal hyperplasia). In 1960, he was begun on Orinase because of a borderline abnormal glucose tolerance curve. In 12/64, the remnant of adrenal gland was removed because of persistent hyperadrenalism. (Gland showed diffuse hypertrophy and hyperplasia.) Steroid replacement was given. His subsequent course was as follows:

9/68 - Increasing skin pigmentation; severe headaches; X-ray - ballooned sella. Later mild adrenal insufficiency, headaches, nausea and vomiting.

12/70 - Pyrachypophysectomy done with post-operative bilateral 6th nerve palsies. Chromophobe adenoma diagnosed.

4/71-73 - Repeated readmissions because of visual problems and Herpes Zoster infection of left eye. Additional craniotomies were done and 7,500 rads applied to head with some improvement of eye signs.

Final admission, 3/74 - low back pain with bilateral generalized motor weakness without focal findings except for absent right knee jerk. Myelogram showed block at T12 and filling defects at L2-4. Decompression and radiotherapy were done for intradural, extramedullary tumor. He died one week after the surgery.

Three Kodachromes are submitted as follows:

Figure 1: Base of brain, tumor on optic nerve and temporal lobe tip.

Figure 2: Tumor in spinal cord.

Figure 3: Microscopic photo, tumor in liver.

One microscopic slide stained with H & E containing tumor involving spinal cord.

Points for discussion:

1. What is the diagnosis of this neoplasm?
2. What is the relationship between the neoplasm and the endocrine dysfunction?