A 70-year-old man presented with a five-day history of worsening headaches associated with vomiting and confusion on the day of admission. He was being treated with warfarin for transient ischemic attacks and left ventricular dysfunction. There was no history of endocrine dysfunction, and he had no visual symptoms. The blood pressure, pulse, and visual fields were normal, and there were no signs of adrenal, gonadal, or thyroid deficiency. The prothrombin time was 26.6 seconds (international normalized ratio, 4.9). The serum concentrations of follicle-stimulating hormone, luteinizing hormone, testosterone, prolactin, thyrotropin, thyroxine, and insulin-like growth factor I were low. The basal serum cortisol concentration was 1.0 µg per deciliter (28 nmol per liter), and it increased to 15.1 µg per deciliter (417 nmol per liter) after the administration of corticotropin. A T₁-weighted magnetic resonance image showed a large soft-tissue mass in the pituitary fossa (solid arrow in Panel A) and areas of intermediate and high intensity (open arrow), suggesting hemorrhage. The addition of gadolinium contrast medium showed that the mass had a heterogeneous pattern of enhancement (arrow in Panel B). These findings are consistent with the occurrence of pituitary apoplexy as a result of hemorrhage or infarction into a nonsecreting pituitary adenoma. The patient was treated with intravenous hydrocortisone, which resulted in rapid improvement, and with levothyroxine. One month later, magnetic resonance imaging showed a substantial decrease in the size of the pituitary mass, with some residual hemorrhage.

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