Pituitary carcinoma is an extremely rare condition and its diagnosis requires the demonstration of cerebrospinal and/or systemic metastasis rather than just local invasion. We hereby present the case of a 64 year old lady who presented with widespread spinal metastasis from a pituitary adenoma 35 years after an initial diagnosis of pituitary adenoma was made.

The lady initially presented in 1971 with complaints of visual loss, headache and oligomenorrhoea. In October 1971 she had a hypophysectomy carried out. The histology revealed a chromophobe adenoma. She remained well until 1979 when there was a recurrence of oligomenorrhoea and deterioration in vision. CAT scan confirmed there was a recurrence of intrasellar tumour and visual fields by perimetry revealed complete left temporal hemianopia. She underwent subtotal removal of recurrent adenoma. Post operatively CAT scan showed a small tumour remnant. She underwent external beam radiotherapy postoperatively. She was lost to follow up until Jan 2007 when she was referred with symptoms of headache, unsteadiness of gait, dizziness and visual problems. On examination she had left temporal hemianopia and left optic nerve atrophy. She underwent CAT scan of the brain that showed a midline mass lesion with mild hydrocephalus. In view of the history of previous surgery and radiotherapy MRI scan of the pituitary was organized, that revealed a pituitary tumour and multiple bilateral posterior fossa lesions. There was also an extensive lesion at craniocervical junction in view of which an MRI scan of the whole spine was performed. This revealed multiple abnormalities in the subarachnoid space the largest being opposite C2, C3. Multiple nodules were seen elsewhere over the cord, becoming fewer with descent. These findings were considered likely due to metastatic disease and CAT scan of chest abdomen and pelvis was carried out to establish the primary lesion. The CAT scans were normal. A biopsy was performed to establish a histological diagnosis. She underwent posterior fossa craniectomy for excision of supracerebellar cervical tumour in Apr 2007. Neuropathology revealed the lesions were pituitary adenoma staining for FSH and LH suggesting the presence of metastatic pituitary adenoma. A subsequent octreotide scan showed no uptake. She has been referred to oncology for further management. This case highlights the importance of life long hospital follow up of patients with pituitary adenoma. It also reveals how spread from pituitary adenoma can occur a number of decades after an initial diagnosis is established.