Expert opinion on pituitary complications in immunotherapy

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Résumé en anglais	Hypophysitis is a frequent toxic endocrine side-effect of immunotherapy. Prevalence is higher with anti-CTLA-4 antibodies (4-20%) or in association with PD-1 inhibitors (8%). Diagnosis is presumptive, based on poorly specific clinical symptoms (usually, headache and asthenia) and/or hyponatremia and/or at least one pituitary deficit and/or abnormal imaging. Visual disorder or polyuropolydipsic syndrome are exceptional. In decreasing order of frequency, deficits are thyrotropic (86-100%), gonadotropic (85-100%) or corticotropic (50-73%); somatotropin deficit or abnormal prolactin level are rarer. Pituitary MRI in acute phase shows variable moderate increase in pituitary volume, ruling out differential diagnoses, especially pituitary metastasis. Treatment of corticotropin deficiency requires systematic emergency replacement therapy, with the usual modalities, while treatment of other deficits depends on clinical status and progression. Thyrotropin and gonadotropin deficits usually recover, but corticotropin deficiency persists over the long term, requiring education and specialized endocrinologic follow-up. Onset of hypophysitis does not contraindicate continuation of immunotherapy and does not usually require high dose synthetic glucocorticoids.
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