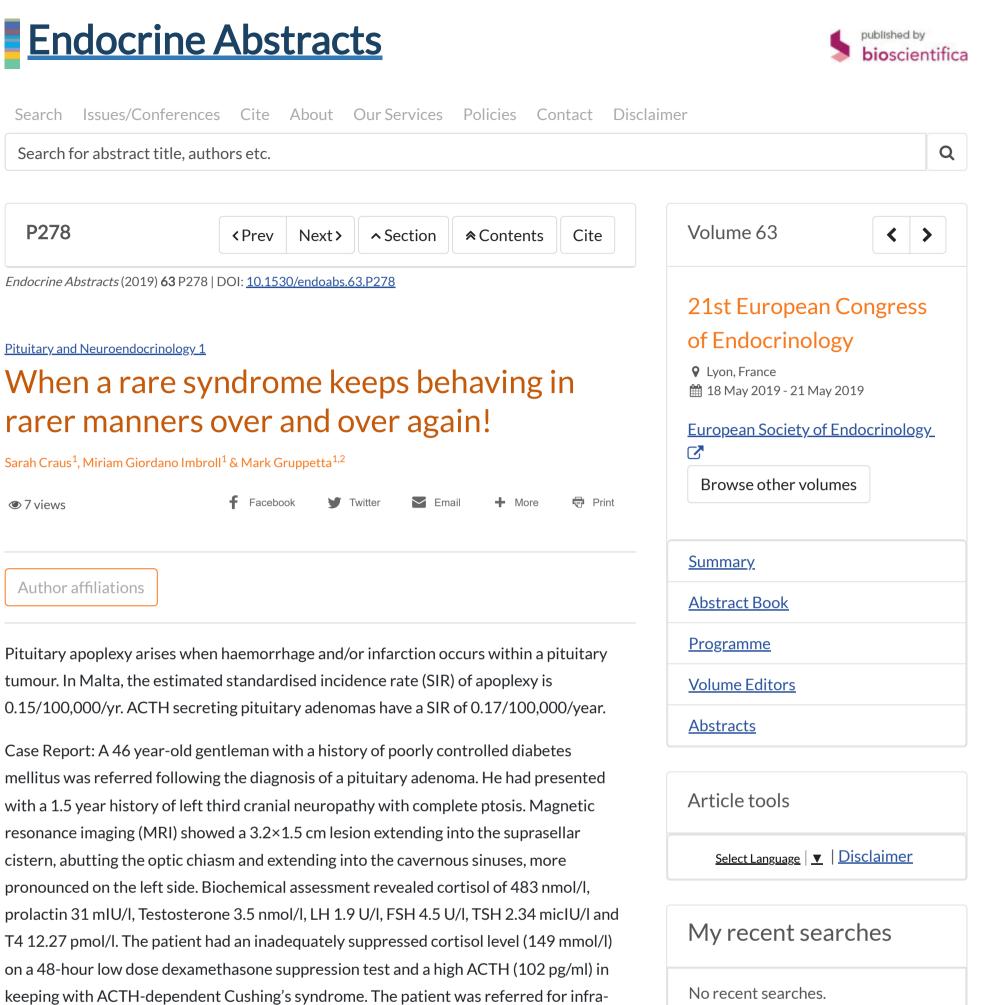
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Ophthalmological assessment revealed a reduction in visual acuity. Areas of hyperintensity in the pituitary adenoma were noted on unenhanced T1 MRI scan and there was lack of enhancement on a contrast scan, in keeping with apoplexy. Urgent debulking was carried out through a trans-sphenoidal approach. Clinical symptoms and visual disturbances showed improvement post-operatively; the right 3rd and 6th CN palsies improved but he had a persistent right temporal visual field defect. Histology confirmed pituitary apoplexy due to tumour infarction of a functional (ACTH secreting) pituitary macroadenoma.

petrosal sinus sampling, which confirmed an ACTH secreting pituitary macroadenoma.

ulcer. He was initiated on Metyrapone in an effort to control his hypercortisolaemia. The

The patient could not undergo surgery at the time in view of an infected diabetic foot

patient presented two months later with severe headache and new onset visual

disturbances. He developed a right III and VI cranial nerve (CN) palsies.

Conclusion: Presentation of Cushing's Disease can be very varied and the work up is extensive and elaborate with a number of different steps. Cushing's syndrome is associated with multiple comorbidities including increased risk of cardiovascular events, neurological consequences osteoporosis and poor quality of life. Hence, it is imperative

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that an early diagnosis is made as early as possible so that the condition is appropriately treated. Although apoplexy is rare, this complication needs to be kept in mind as an inherent risk when managing patients with pituitary adenomas.

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