Short report

Thyrotropin secreting pituitary tumours: a cause of hyperthyroidism

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Summary Pituitary thyrotropin excess resulting in hyperthyroidism has been previously reported in only 25 patients, of whom 19 had a pituitary tumour. This report describes a patient in whom a thyrotropin-producing pituitary tumour was associated with triiodothyronine thyrotoxicosis. Hypophysectomy was followed by a prompt fall in serum thyrotropin and a return to a euthyroid state.

Excessive pituitary thyrotropin (TSH) secretion is one of the least common causes of hyperthyroidism. The 25 cases described so far can be classified in two groups (table). The first consists of 19 patients who had radiological evidence of sellar enlargement, necessitating hypophysectomy or pituitary irradiation or both. The second group consists of six patients who had no sellar enlargement. This report describes a patient in whom excessive TSH production by a pituitary tumour resulted in triiodothyronine (T₃) thyrotoxicosis. Previously reported cases of TSH-induced hyperthyroidism are reviewed.

Case report

A 31-year-old man first presented in 1970, at the age of 24 years, with hyperthyroidism of two months duration, associated with a diffusely and symmetrically enlarged thyroid. Eye examination was normal but there is no record of the visual field examination. Thyroidal I¹³¹ uptake was 79% at four hours and 75% at 24 and 48 hours. Serum thyroxine (T₄) was 87.5 nmol/l (normal range, 57-9-154). Although no direct measurement of serum T₃ was available then, the provisional diagnosis was T₃-thyrotoxicosis. Treatment with methimazole, 30 mg per day, resulted in amelioration of the patient's symptoms but the goitre persisted. Treatment was continued for two years, but three months after its discontinuation the hyperthyroid state reappeared necessitating reinstitution of the same antithyroid regimen for an additional two years. In 1974, a subtotal thyroidectomy was performed at another hospital. Histopathological examination of the excised tissue was reported as thyroid hyperplasia.

Eighteen months after the thyroidectomy, the hyperthyroid state reappeared gradually. Physical examination in February 1977 revealed a regular pulse rate of 120/min, a warm moist skin and a diffusely enlarged thyroid, about four times normal size. There was no exophthalmos or skin abnormality. There was a bitemporal visual field defect more pronounced on the left side. Serum T₄ was 70·8 nmol/l serum T₃ was 8·77 nmol/l (normal 1·08-2·92) and I¹³¹ uptake 81% at four hours and 82% at 24 hours. Serum TSH, determined by radioimmunoassay was 46 μU/ml (normal range, 2–8 μU/ml). (The TSH standard employed was calibrated against MRC TSH standard 68/38.) Antithyroglobulin antibodies were not detected in the serum. Serum proteins, calcium and inorganic phosphate were normal. Random urinary specific gravity ranged from 1·017 to 1·024. Serum growth hormone, prolactin, follicle stimulating hormone (FSH), luteinising hormone (LH), testosterone and cortisol as well as urinary 17-ketosteroids, and 17-hydroxysteroids were all normal. Except for the measurement of serum T₃, the methods for hormonal determinations have been described previously.
Skull radiography showed a markedly enlarged sella turcica with erosion of the dorsum sellae. Bilateral carotid arteriography showed unfolding and lateral displacement of the carotid siphons.

Treatment with methimazole, 30 mg per day resulted within one month in a gradual fall in serum T₄ and T₃ levels and a concomitant rise in serum TSH levels. When the patient became euthyroid (serum T₃ 2-0 nmol/l, serum T₄ 64·3 nmol/l), the intravenous administration of 400 μg of thyrotropin-releasing hormone (TRH) resulted in a brisk rise in serum TSH levels, from a baseline of 600 μU/ml to 2600 μU/ml within 30 minutes. There was a minimal rise in serum prolactin.

Two weeks later, a hypophysectomy was performed through a sub-frontal approach. A large pituitary tumour weighing about 10 g was excised. Postoperatively, there was a rapid fall in serum TSH levels reaching 50 μU/ml in 24 hours and a normal level of 3-8 μU/ml by the twelfth post-operative day. On a regular monthly follow-up for the subsequent 32 months, the patient was asymptomatic and there was gradual and complete regression of the thyroid enlargement. Serial serum TSH determinations ranged from 4·5 to 6·5 μU/ml, serum T₄ from 79·8–95·2 nmol/l and serum T₃ from 1·23–2·0 nmol/l. Visual field examination showed significant improvement in the previous defects. Repeat skull radiographs showed no further increase in sellar size. Adrenal and testicular functions continued to be normal. The patient was not given pituitary irradiation.

Histological examination of the tumour revealed the parenchymal component to consist primarily of sheets of angular polyhedral cells with a finely granular cytoplasm (fig. A). Several staining procedures were used on paraffin sections and all revealed intracellular granules with the staining characteristics of thyrotropes.²⁵ –²⁷ Electron microscopic examination showed cells with many cytoplasmic granules varying in size between 100 and 200 nm in diameter, a feature characteristic of thyrotropes²⁸ (fig, B). TSH content of a 60 mg portion of the tumour homogenised in 50 ml of 0·1 M phosphate buffer (pH 7·4), determined by radioimmunoassay, was 2330 μU/mg of wet tissue. In the same homogenate, no detectable amounts of growth hormone, prolactin, LH or FSH could be found.

**Discussion**

It is well known that in the hyperthyroidism of Grave's disease, toxic nodular goitre or a toxic adenoma, serum TSH levels are usually suppressed, often to undetectable levels. The presence of elevated serum TSH levels in hyperthyroidism together with a pituitary tumour, suggests the rare condition of pituitary thyrotropin hypersecre-
Thyrotropin secreting pituitary tumours: a cause of hyperthyroidism

Figure (A) Photomicrograph of pituitary tumour showing angular polyhedral cells with finely granular cytoplasm. Magnification X780, aldehyde fuchsin counterstained with Ehrlich's hematoxylin.

tion as the cause of thyroid hyperfunction. In the patient described here, this possibility is substantiated by the prompt and sustained fall in serum TSH and amelioration of the thyroid enlargement and hyperthyroidism following the surgical removal of the tumour. Moreover, this patient had no exophthalmos or other stigmata of Graves' disease. The occurrence of pure T₃ thyrotoxicosis in this patient may have been related to the fact that he was living in an iodine-deficient area. However, an alternate explanation might be that excessive TSH stimulation results in a preferentially higher T₃ than T₄ secretion as shown by the fall of the serum T₃ over T₄ ratio after the hypophysectomy.

The previously reported 19 cases of TSH-producing tumours with hyperthyroidism are briefly summarised in the table. Unlike the usual female preponderance in the other common causes of hyperthyroidism, the female to male ratio in this group was only 10 to 9. However, the age range was not different from that of the common causes of hyperthyroidism. The average duration of the thyrotoxic state until the time of diagnosis of TSH hypersecretion was approximately 3-3 years. It is possible that this relatively long duration reflects the fact that the specific diagnosis of TSH excess is often arrived at late because of the rare nature of this condition. Another interesting feature of TSH-producing tumours is the relatively high incidence of concomitant hypersecretion of growth hormone in five patients and prolactin in three others (table). While this observation might imply the occurrence of tumours of mixed cellular types, its pathogenesis remains unexplained. Its significance lies in that it makes the search for TSH excess, which could be occult, advisable in patients with acromegaly or prolactinomas.

The autonomy of TSH secretion in patients with TSH producing tumours appears to be variable. In the ten patients who were tested with intravenous TRH, only two responded with a rise in serum TSH while the other eight patients did not show any response. Antithyroid treatment, causing a fall of serum thyroid hormones to normal, resulted in a further rise in serum TSH in five
Ibrahim S Salti, Nuha Nuwayri-Salti, Ronald A Bergman et al

Figure (B) Electron micrograph showing portions of tumour cells. The nuclei (N) contain dense clumped chromatin and a fine granular texture. The cytoplasm contains granules (G) which are enveloped in membranes and appear to emanate in close relationship to the nucleus (straight arrows). Lipochrome pigment granules (L) are also seen. The cell membrane is indicated by a curved arrow. Original magnification ×8800.

patients but not in two others. Thus it appears that at least a few of the tumours were not completely autonomous and responded to TRH administration or changes in circulating levels of thyroid hormones or both.

The six patients in whom no sellar enlargement was found (cases 20–25, table) may not necessarily comprise a homogeneous group. It is conceivable that some of them might have had small pituitary microadenomas which were too small to be detected by routine radiography of the skull. In two patients, the authors attributed the inappropriate TSH hypersecretion to a selective pituitary resistance to the suppressive effect of thyroid hormones.20 21 Five out of the six patients had a brisk rise in serum TSH after TRH administration. Thus it appears that in this group of patients, TSH hypersecretion is relatively less autonomous than in the group with overt pituitary tumours. The same findings were reported by Kourides et al22 in their study of TSH sub-units in thyrotropin-induced hyperthyroidism.

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Thyrotropin secreting pituitary tumours: a cause of hyperthyroidism

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