17 year old female with primary amenorrhea

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Fellow section of Endocrinology Diabetes and Metabolism 09/11/2014

HPI

- **❖17** year old white female no significant PMH
- ❖c/o Primary amenorrhea
- **❖ Reported visual disturbance (haziness in the lateral visual fields, changes in depth perception)**
- **❖VF** → Peripheral visual loss
- ❖No h/o headache, N/V/D, Wt change, galactorrhea or skin tags

PMH:

✓ Primary amenorrhea

Family History:

- ✓ Type 2 DM (mother/maternal aunt)
- ✓ no h/o CNS tumors

Social history

✓ In school, lives with parents

Home medications

None

ROS

Constitutional: Negative for fevers, chills, night sweats, or heat/cold intolerance.

HEENT: Negative for headaches, tinnitus, rhinorrhea, sore throat. + visual

disturbance

Respiratory: Negative for cough, wheezing

Cardiovascular: Negative for nausea, vomiting, chest pain, shortness of breath,

lightheadedness, palpitations

Gastrointestinal: nausea and vomiting present Negative for abdominal pain,

diarrhea, constipation

Genitourinary: no polyuria no hematuria

Skin: Negative for diaphoresis, new rash

Musculoskeletal: Negative for myalgia

Neurological: Negative for weakness, numbness, tingling

All other systems reviewed and are unremarkable

On examination

Vitals: BP 110/68, Pulse 88, no fever, RR 14

General: awake alert, comfortable

HEENT: normocephalic non traumatic, no pallor, no jaundice. Mild

hirsutism

Neck: supple, no thyromegaly, no lymphadenopathy

CVS/Pulm: good air entry bilateral, no added sounds

Abd: soft, non tender, no Organomegaly, audible bowel sounds.

Skin: no ulcers, not diaphoretic, no acanthosis nigricans

Neuro: alert, no tremor, CN intact, DTR normal, sensation intact

Psych: normal mood, and affect

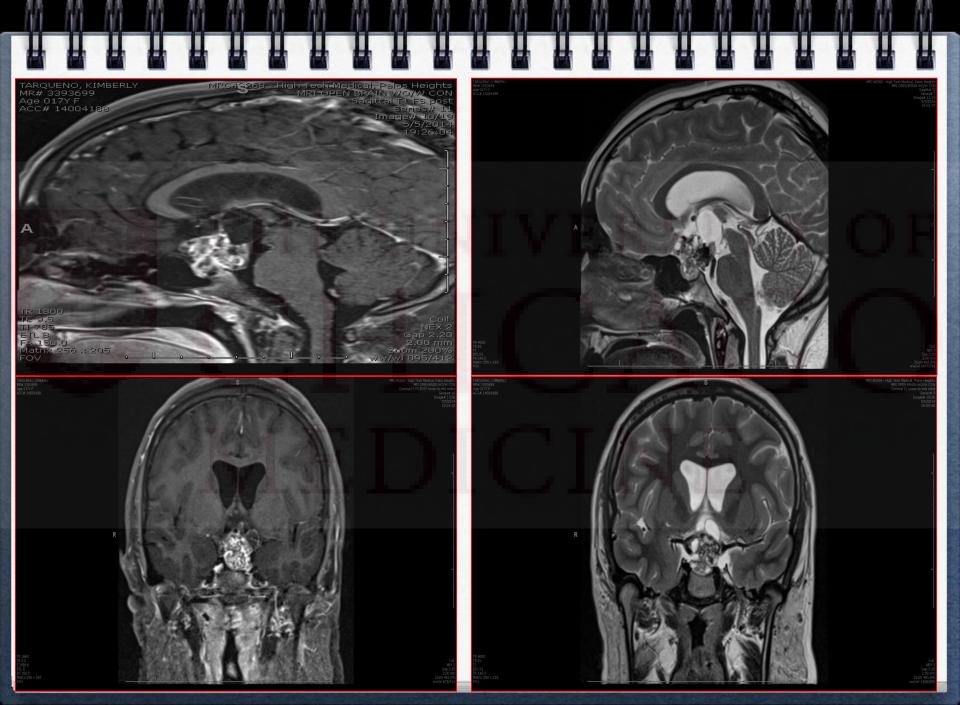
General labs on admission

Test/date	5/15/2014			
Na/K	144/4.1			
Glucose	82			
Cr/GFR	0.6/>120			
Albumin	4.4			
ALP	134			
ALT/AST	22/25			
Hb	10.9			
WBC	8			
Plt	278			
Ca	9.9			

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Endocrine labs

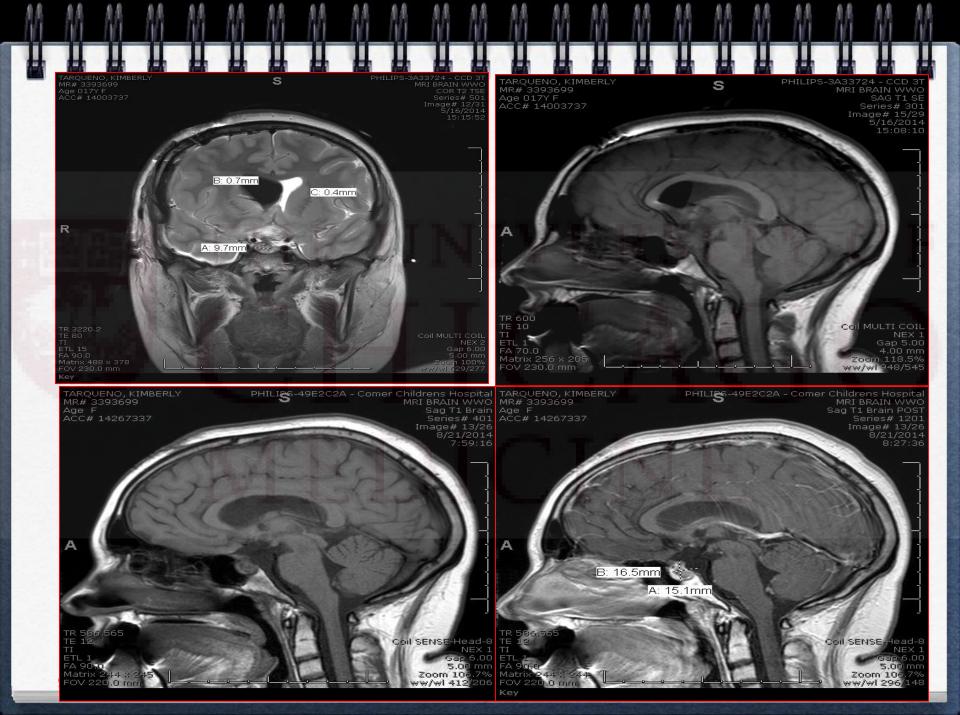
Test/date	On admission
ACTH	32.1
Cortisol (10 am)	11.3
E2	<10
LH (2.0 -84 miu/ml)	2.1
FSH (3.9 -8.3 miu/ml)	5.9
Pregnancy test	Negative
PRL	7.55
IGF-1 (20-200 ng/ml)	4.1
TSH	2.02
FT4	1.12



Management

- Rt Craniotomy (Tumor resection) by Dr. Lesniak
- Close monitoring of vital signs and frequent neurological exam.
- Pathology → Adamantinomatous craniopharyngiomas (WHO grade I)

MEDICINE

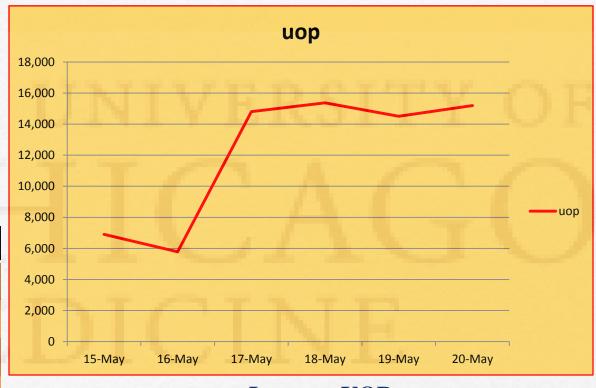


Post-op Course

Started on

- Stress dose steroid
- LT4 50 mcg daily
- DDAVP added

Test/date	5/17
U Na	12
U osm	< 100
P Osm	301
U SG	1.005



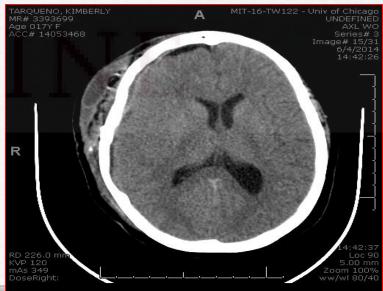
Increase UOP

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Test/date	5/15	5/16	5/17	5/19	5/21	5/24
Na	144	161	156	147	142	143

- Discharged on 5/27
- 5 days after discharge → readmitted with worsening swelling around Rt eye
- She underwent a CT scan on 6/4/14 which found a right-sided frontal and parietal subdural collection.
- Started on Vaco/Cefepime
- Sub-galeal fluid collection was sampled which was largely bloody and found to have MSSA on culture
- Antibiotics changed to IV Oxacillin (6 weeks)
- Currently receiving radiation therapy





Repeated TFT

Test/date	5/15	5 wks post op
TSH (0.3 – 4.0 mcu/ml)	2.02	0.22
FT4 (0.9 -1.7 ng/dl)	1.12	0.50

Levothyroxine dose increased to 75 mcg daily

Thank you

Milad Abusag MD 09/11/2014