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Postpartum amenorrhoea-galactorrhoea

To the editor,

With interest I read the article from my former colleagues Kroese, Grootendorst and Schelfhout.[1] The conclusion that amenorrhoea, galactorrhoea and hyperprolactinaemia associated with enlargement of the pituitary gland are caused by primary hypothyroidism may be correct and is very well supported by the literature. At first glance, the case is clear-cut and other possibilities seem to have been ruled out sufficiently.

In the last paragraph of the discussion the authors state that 'hypothyroidism and hyperprolactinaemia with pituitary enlargement can cause diagnostic difficulties'. Their differential diagnosis consists of 'coexistence of primary hypothyroidism and a pituitary macroadenoma' and 'primary hypothyroidism associated with hyperprolactinaemia and pituitary enlargement'. The former diagnosis was ruled out by the fact that 'replacement therapy with L-thyroxin was associated with the resolution of pituitary enlargement and resumption of the menstrual cycle'. Another possible diagnosis that has not been ruled out in my opinion is the coexistence of primary hypothyroidism and lymphocytic hypophysitis.

Lymphocyte hypophysitis is a rare condition that occurs almost exclusively in young women and has a temporal relationship to pregnancy or (early) postpartum period.[2] It mimics a pituitary tumour and may lead to visual disturbances and to a varying degree of pituitary hormone deficiencies.[3,4] In many patients, transsphenoidal surgical exploration is performed because of a presumed non-secreting pituitary macro-adenoma. Histopathological examination shows extensive mononuclear infiltration of the anterior pituitary gland.[3]

The pathogenesis of lymphocytic hypophysitis is uncertain but autoimmune mechanisms are probably involved. In this context, primary hypothyroidism and lymphocytic hypophysitis may be connected. Of the five patients with lymphocytic hypophysitis reported by Patel et al., one developed thyroiditis.[4] Other authors have also reported lymphocytic hypophysitis, in most cases biopsy proven, in association with autoimmune primary hypothyroidism.[5-8]

On the basis of these reports, coexistence of primary hypothyroidism and lymphocytic hypophysitis may be a plausible explanation. On the basis of 'the resolution of the pituitary enlargement and the resumption of the menstrual cycle after replacement therapy with L-thyroxin' it was concluded that 'primary hypothyroidism was the factor causing the pituitary dysfunction'. However, it should be noted that lymphocytic hypophysitis, when not operated, often runs a benign course with pituitary function spontaneously returning to normal.

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