few cases of infundibular/sellar epidermoid cysts have been described. We present the case of a large sellar epidermoid cyst resulting in panhypopituitarism.

Case: 49 year old male with history of obesity and hypertension presented to the emergency department with acute onset progressively worsening headaches. He denied vision changes, nausea, vomiting or dizziness. Examination showed stable vital signs and ophthalmologic exam did not reveal any visual deficits. Further, he did not have any signs of pituitary hormone excess including hypercortisolism or acromegaly. Brain MRI with and without IV contrast revealed a peripherally enhancing multilobulated cystic pituitary mass measuring 19.5 mm×17 mm×20.5 mm deviating the infundibulum to the left causing compression of the caudal aspect of the optic chiasm. Initial endocrinology work-up revealed noon time cortisol of 10.7 mcg/dL (range 7-23), 7 pm ACTH of 34.6 pg/mL (range 7.2-63.3), TSH of 1.71 mIU/mL (range 0.35-4.94), free T4 of 0.93 ng/dL (range 0.5-1.39), FSH of 4.45 mIU/mL (range 1.27-19.26), LH 5.51 mIU/mL (range 1.24-8.62), IGF-1 level of 199 ng/mL (range 68-225), prolactin <0.60 ng/mL (range 2.64-13.13), and testosterone level of 186 ng/dL (range 175-800). A presumed diagnosis of non-functioning pituitary macroadenoma with compression of chiasm was made and he underwent transsphenoidal hypophysectomy after evaluation by a multi-disciplinary team including neurosurgery, ENT and endocrinology. Post-operative course was uneventful, he was started on empiric steroids which were tapered slowly. Final pathology of surgical specimen demonstrated epidermoid cyst, focal necrosis, lymphocytes and macrophages infiltration consistent with reactive granulation tissue. On subsequent laboratory evaluation, he was found to have hypogonadotropic hypogonadism with an undetectable testosterone. FT4 was also low at 0.61 ng/dL (range 0.5-1.39). He is closely following with endocrinology for management of hypogonadotropic hypogonadism and hypothyroidism.

Conclusion: Intracranial epidermoid cysts are uncommon benign congenital lesions arising from trapped surface of ectodermal elements. Very rarely, they are found in the sellar region. Sellar epidermoid cysts tend to present late and often after significant growth and mass effects. Complete resection is challenging and recurrence is a feared complication. Our patient presented with acute symptoms from expansion of a large epidermoid sellar cyst mimicking a pituitary macroadenoma. It also resulted in hypopituitarism. Although, a rare entity, early recognition and prompt management of such lesions is key.

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A Rare Case of an Intrasellar Epidermoid Cyst And Panhypopituitarism
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Introduction: Epidermoid cysts are rare intracranially occurring mainly in subarachnoid spaces such as parasellar cisterns, middle fossa and cerebellopontine angle. Only