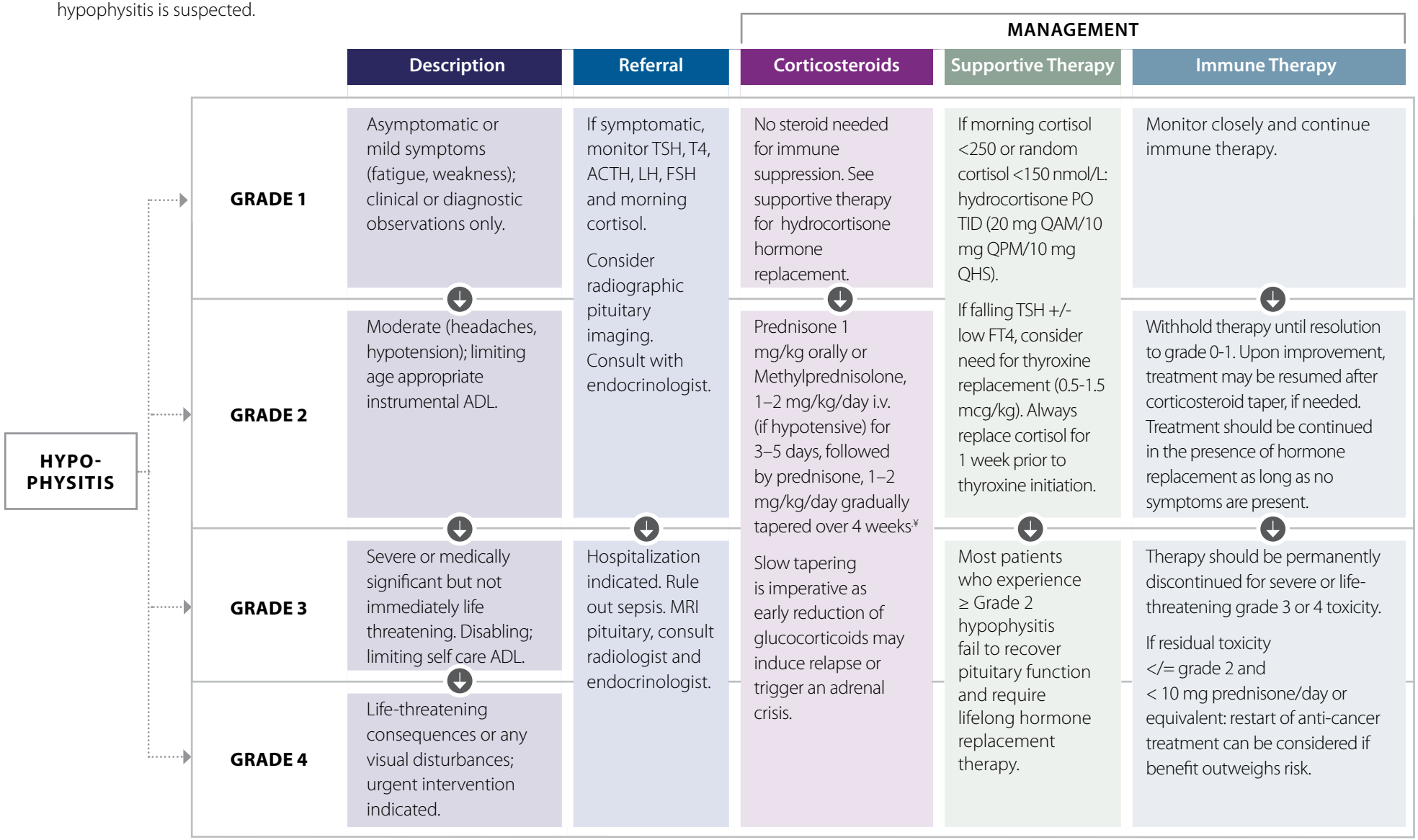
FIGURE 5

Management of Immune-Related Hypophysitis[2,4,10,13,14,17,23,24,25]

Background: The incidence of hypophysitis is highest in anti-CTLA4 therapy (1%) and in combination therapy (8%). It occurs more frequently in males and usually occurs after 2-6 months of treatment. Hypophysitis can remain undetected since the symptoms might be vague[§] Laboratory testing of morning cortisol, adrenocorticotropic hormone (ACTH), luteinizing hormone (LH), follicle stimulating hormone (FSH) and growth hormone (GH) define the diagnosis. Hypophysitis presents with low TSH and low free T4. Radiographic imaging (MRI) of the brain and pituitary gland may be warranted to identify lesions such as pituitary adenomas that may require intervention. Hormone replacement should be initiated according to hormone dysfunction and is usually long-term. An endocrinologist should be involved and consulted as soon as hypophysitis is suspected.



§ nonspecific symptoms such as headache, visual impairment, fatigue, weakness, confusion, memory loss, erectile dysfunction and loss of libido, anorexia, labile moods, insomnia, temperature intolerance, subjective sensation of fever, and chills.
¥ Alternatively dexamethasone, 4 mg every 6 hours for 1 week, gradually tapered to 0.5 mg/d, with substitution to replacement doses of hydrocortisone.