

Prolactin

HOSP #		WARD	ENT Clinic
CONSULTANT		DOB/AGE	35 Y Male

Abnormal Result

Prolactin 10 986.0 ug/L (4-15.2)

Dilutions:

1/10 >4700;

1/100 = 10821;

1/50 = 10 986.

Presenting Complaint

Epistaxis

History

Patient with epistaxis referred to the ENT specialist clinic.
No relevant medication history.

Examination

35 y male with a large left post-nasal space mass, a vascular mass involving the pituitary fossa.

?NBL (non-benign lesion)

?Sinonasal malignancy

?Pituitary Tumour

Laboratory Investigations

TSH 0.91 pmol/L (0.27-4.20)

Free T4 15.7 pmol/L (12-22)

FSH 0.8 IU/L ↓ (1.5-12.4)

LH 0.2 IU/L ↓ (1.7-8.6)

Testosterone 0.2 nmol/L ↓ (8.6-29.0)

PTH 1.7 pmol/L (1.6-6.9)

Prolactin measuring method:

The Elecsys prolactin sandwich immunoassay uses two monoclonal antibodies directed against human prolactin.

R1 = biotinylated antibody – recognizes the N-terminal end of the prolactin molecule

R2 – ruthenium complexed antibody probably reacts with a region in the middle of the prolactin molecule.

1st incubation: a biotinylated monoclonal prolactin-specific antibody and a monoclonal prolactin-specific antibody labeled with a ruthenium complex form a sandwich complex.

2nd incubation: after addition of streptavidin-coated microparticles, the complex becomes bound to the solid phase via interaction of biotin and streptavidin.

Reaction mixture aspirated into the measuring cell where microparticles are magnetically captured into the surface of the electrode.

Unbound substances are then removed with ProCell.

Application of a voltage to the electrode then induces chemiluminescent emission which is measured by a photomultiplier, results calculated by a standard curve.

Other Investigations

Monomeric prolactin – 7744 ug/L (70% recovery after PEG precipitation)

Biopsy: confirmed tumour stained strongly positive with prolactin suggesting a prolactinoma.

Final Diagnosis

Pituitary Macroprolactinoma

Take Home Messages

Sandwich immunoassays are prone to high dose hook-effect. There are various ways to overcome this effect. (This will later be expanded on – see AFP / Beta-HCG).

Prolactin appears in the serum as:

1. Active monomeric prolactin (“little”) (80%) 23kDa
2. Inactive dimeric prolactin (“big”) (5-20%) 50-60kDa
3. Low activity tetrameric prolactin (“big-big”) (0.5-5%) 150-170kDa

Precipitation by PEG yields the active monomeric

prolactin, expressed as a percentage recovery after precipitation. Big-big prolactin consists of an antigen-antibody complex of monomeric prolactin-immunoglobulin G and is defined as macroprolactin. This has a long half-life in blood when compared to normal prolactin and gives false high readings of prolactin, leading to unnecessary investigations in certain cases. A high prolactin should thus be confirmed by doing a PEG precipitation.

ACTH

HOSP #		WARD	G16 Medical Ward
CONSULTANT		DOB/AGE	54 y Female

Abnormal Result

21/08/2018 Two ACTH tests (referred to another laboratory) and two

Cortisol levels (at our laboratory) were done.

At first it was thought to be a dexamethasone suppression test, but then

realized the clinicians were suspecting hypopituitarism.

10h05: **ACTH 0.7 pmol/L ↓** (1.6-13.9) Cortisol 8 nmol/L ↓
(Morning: 133- 537; Afternoon 68 – 327)

10h35: ACTH 1.8 pmol/L N (1.6-13.9)
Cortisol 68 nmol/L ↓ (Morning: 133- 537; Afternoon 68 – 327)

Presenting Complaint

? hypopituitarism

History

Known with a pituitary macroadenoma, previously seen at the Radiotherapy clinic in 2016.

Examination

No clinical info available.

For Primary adrenal insufficiency one would expect:
Hyperpigmentation
(due to ↑ ACTH), +/- hyperkalemia/hyponatremia (aldosterone effect), +/-
virilization.

For Secondary adrenal insufficiency there is subtle symptoms, electrolytes are not deranged significantly because aldosterone function is preserved. See table on Bishop 7th ed. p. 459.

Laboratory Investigations

Measurement of
plasma ACTH concentration is used to assess Cushing's disease, adrenal tumors, ectopic ACTH-producing tumors, Addison's disease, Nelson's syndrome, and hypopituitarism.

The
laboratory diagnosis of hypopituitarism, however is relatively straightforward.

In contrast to the primary failure of an endocrine gland that

is accompanied by dramatic increases in circulating levels of the corresponding pituitary tropic hormone, secondary failure (hypopituitarism) is associated with low or normal levels of tropic hormone. This is the diagnosis in this case with the history of previous radiotherapy which was given for a macro-adenoma.

Other Investigations

Free T4 on 19/04/2018 was 7.8 pmol/L (12-22), also suggesting possible hypopituitarism, although a TSH would be helpful.

Final Diagnosis

Hypopituitarism confirmed.

Take Home Messages

Dexamethasone suppression test need only measurement of cortisol, not accompanying ACTH, except in extended work-up however, where a Cosyntropin (CRH) stimulation test can be done to distinguish between pituitary or hypothalamic insufficiency.

Evaluation of pituitary function need the Primary hormone (Cortisol) as well as the tropic hormones from the pituitary (ACTH).