introduction reiterated what has been noted previously: the classic belief that this condition occurs exclusively in women. This is no longer true. We[2] recently reported the first documented case in a man who presented with a pituitary mass and hypopituitarism. This condition resembles other autoimmune endocrine disorders in that it occurs predominantly, but not exclusively, in women. Pregnancy has also long been known to exacerbate many autoimmune disorders, including those not restricted to the endocrine system.

The authors also quoted Asa and associates,[3] stating that the affected pituitary area shows negative immunohistochemical staining for functional pituitary cells. Studies on our patient revealed positive staining with all antisera studied (LH, FSH, ACTH, TSH, PRL, GH), indicating the presence of all pituitary cell types. No one stain was predominant. Lack of predominant staining correlated with serum hormone levels in that none of the peripheral hormone levels were elevated.

We concur with the authors that the etiology of lymphocytic hypophysitis, whether it involves cellular or humoral immunity, is still uncertain.

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REPLY:

We thank Dr. Guay and colleagues for bringing this case of lymphocytic adenohypophysitis to our attention. Since submission of our case reports, several others have appeared in the literature.[1-3] Certainly Dr. Guay's case is unique as it is the only biopsy proven case of lymphocytic adenohypophysitis in a man. However, Barken et al reported two men with polyglandular autoimmune syndromes with selective pituitary gonadotrope failure.[4] They suggested that autoimmune hypophysitis may be an integral part of the polyglandular autoimmune syndromes and can be selective involving only one cell type.

It is true that immunohistochemical staining can reveal immunoreactive hormones within surviving adenohypophyseal cells, but in areas of cell injury, staining for functional cells may yield negative results. In some cases cells are so badly damaged that they cannot be classified by electron microscopy.[5] This may explain the high incidence of panhypopituitarism in cases when unselective cell destruction occurs. It is interesting to note that in spite of positive staining with all antisera studies (PRL, FSH, ACTH, TSH, LH, GH) the patient reported by Dr. Guay had clinical and biochemical evidence of anterior hypopituitarism.

In our first case, immunohistochemical staining revealed only growth hormone and prolactin in a few surviving adenohypophyseal cells. Since only a limited decompression was carried out, possibly further samples from a less severely involved portion of the gland would have demonstrated other functional cell types on immunohistochemical staining.

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