Sheehan's Syndrome (A Case Report)

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Pituitary ischaemia and necrosis associated with obstetrical blood loss may cause pan hypopituitarism and is referred to as Sheehan's Syndrome. The incidence is now less than 1 in 10,000 deliveries due to better obstetric care. Mrs. XYZ, a 36 year old housewife presented in our hospital referred from a physician with the chief compliants of dyspareunia. She was a known case of Sheehan's Syndrome. In her past history, she had a full term, vertex vaginal delivery of a male child 3.1 kg. During the delivery she had severe atonic postpartum heamorrhage. Her hemoglobin then was 4mg/dl, and she was given 6 units of whole blood transfusion. Subsequently, she had failure of lactation and seconday amenorrhoea, for which she was treated by a private gynecologist with oral hormonal pills. However, she did not respond and did not continue any treatment. Four years later, she had an episode of sudden onset of giddiness and was admitted in a delirious and drowsy state in a private hospital. There she was diagnosed as a case of hyponatremic metabolic encephalopathy with disseminated Koch's with secondary hypothyroidism and seconday amenorrhoea due to Sheehan's syndrome with anemia. She was treated for the same. Her investigations were : 17/3/1999: Hb-7g/dl; CBC-10, 900/cmm; Sr. FSH-1.31mlU/ml, Sr. LH-1.0mlU/ml; Sr. Prolactin-3ng/ml; Sr. T3-19.0ng/dl; Sr. T4-2.9 mgm/dl; Sr. TSH-0.3 mlU/ml; Sr. Cortisol-1.1 mgm/dl, all of which were less than the normal values. Sr. Na was 122mEq/L; Sr. K-3.9 mEq/L and Sr. C1 was 98 mEq/L. After electrolyte correction, she was started on steroid and thyroid supplementation, anti Koch's treatment, hematinics and discharged. Due to non compliance, she presented again on 17/7/2000 to the physician's at our hospital in altered sensorium due to hyponatremic metabolic encephalopathy. Electrolytes were corrected, thyroid and steroid supplementation was restarted. Her general condition was stablised and she was referred to us for dyspareunia. On examination, her vitals were normal; PA-soft; PS-NAD; PV – uterus less than normal size, mobile, fornices were clear. Her investigations were : Sr. FSH-2.1mlU/Ml; Sr. LH-1.48 mlU/ml; Sr. Prolactin-3.1ng/ml; Sr. Cortisol-not detected; Sr. ACTH-28pg/ml; Sr.T3-35 ng/dl; Sr. T4-3.01 mgm/dl; Sr. TSH-0.21 mlU/ml; all of which were on the lower side of normal values. USG of the pelvis revealed hypoplastic uterus 3 cm x 1.6cm x 2.6cm with no adnexal pathology. MRI of the sella turcica revealed an empty sella. She was explained about her significant medical condition and started on Estrogen-Progesterone replacement therapy. She was counseled and advised regular follow up and treatment, Patient followed up after 4 months in Nov 2000 and was taking steroid and thyroid replacement. Also she had stopped E-P therapy as she could not afford it, no further investigations were done, patient has not come for follow up after Nov 2000.