provoked by gastric atrophy is the commonest cause of VBD. Autoimmune atrophic gastritis (AAG) is a special type of gastric atrophy characterized by serum antibodies antiparietal cells and/or anti-intrinsic factor. AAG was an unexpected diagnosis since it is a relatively rare disease and the peak age of onset is 60 years, with only 10% of patients being <40 years of age. Myelopathy alone as clinical presentation is also a rare situation, occurring in about 12% of patients. Concerning on imagiological findings, there was not only the involvement of the posterior column, but also of the lateral column, rarely involved in SCD. Attention must be taken since AAG increases the risk of gastric carcinoid tumors and gastric carcinoma.

So, although being a rare condition, mainly in that age group, AAG needs to be remembered concerning its treatable nature and malignant potential that requires an appropriate follow-up.

References

Clinically nonfunctioning pituitary adenoma growth after radiosurgery
Crescimento de adenoma pituitário clinicamente não funcionante após radiocirurgia

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Radiosurgery (RS) is a minimally invasive technique suitable for lesions of the central nervous system (CNS), with <3 cm in diameter or volume <30 mL. Benign tumors of the CNS are candidates to perform RS. It has emerged as a therapeutic option for clinically nonfunctioning pituitary adenomas (CNFPA), associated with effective control of tumor growth and few complications. About 30% of pituitary adenomas are classified as CNFPA, and patients with this tumor usually have clinical symptoms, such as headaches, visual loss, hypopituitarism and, less commonly, pituitary apoplexy. These tumors often develop slowly, but diagnosis tends to be late. Surgery is the primary treatment option, preferably transsphenoidal, complemented or not by radiotherapy (RT) or RS. In cases of tumor residues, the therapeutic approach remains controversial.

Efficacy and safety of RS in CNFPA have not been evaluated as adequately as in functioning pituitary adenomas. In three series of patients, with a follow-up period longer than a year, RS produced tumor shrinkage in about 75% of cases. The remaining patients had stable lesions or progressive disease. These results are comparable to those obtained with surgical treatment, but with fewer complications. Therefore, RS is a viable alternative to surgery for the treatment of CNFPA.

Fig 1. Before radiosurgery. Cranial nuclear magnetic resonance scan from March, 2004, revealing probable tumor residues, measuring 2.5 x 2.0 x 1.5 cm, with greater involvement of the sphenoid sinus.
than 48 months, RS was able to control tumor growth in 93 to 96% of the cases\textsuperscript{1-3}.

Complications of RS are optic neuropathy, lesions in adjacent vascular structures, parenchymal brain injury, hypopituitarism, and neoplasms\textsuperscript{1-4}. Stenosis or occlusion of the internal carotid artery has already been reported\textsuperscript{5}.

**CASE**

We reported a case of a patient with CNFPA who underwent RS and showed tumor growth after it.

A 59-year-old male patient, single, born in São Paulo, Brazil, reported that a cranial computed tomography (CCT) performed in 1992 by headache had identified sellar and suprasellar tumors with 2.0 x 2.0 cm. In 2001, the CCT was repeated and revealed a slight increase (2.2 x 2.0 cm) of them. The patient denied headaches or visual loss.

Hormonal evaluation did not identify any changes. Nuclear magnetic resonance (NMR) scan showed sellar tumor with supra- and infrasellar extension, measuring 2.2 x 2.5 x 2.8 cm, isointense on T1 and hyperintense on T2, with compression of the optic chiasm. Transphenoidal pituitary surgery was performed in 2001.

The anatomicopathologic diagnosed pituitary adenoma with discrete anaplasia and sites reagent for thyroid-stimulating hormone (TSH) in the cytoplasm.

Cranial NMR was repeated in 2001, 2002, and 2003, and scans revealed intrasellar content, with no signs indicating tumor residues. In 2004, NMR demonstrated residues with 2.5 x 2.0 x 1.5 cm.

RS was underwent in March, 2004 (Fig 1). NMR sellar was underwent in June and September, 2004 (Fig 2), with lesion growth in six months. In January, 2005, NMR revealed a significant reduction in tumor volume to about 1.5 cm.

A possible explanation to growth and subsequently regression after RS is the occurrence of apoplexy. Reports of pituitary apoplexy cases after RT have promoted a relationship between apoplexy and radiation\textsuperscript{1}. Radiation is known to increase vascularization of pituitary adenomas, therefore leading to apoplexy.

RS is an alternative for the treatment of CNFPA, however, there are no reports of pituitary apoplexy or tumor growth after RS. A possible reabsorption of the apoplectic content leading to subsequent regression is likely. Tumor growth after RS, probably due to pituitary apoplexy, may be a possible complication of this therapeutic modality.

**References**