CASE REPORT

Case Report: Hyperprolactinemia and growth hormone deficiency associated with Morning Glory Syndrome; with a review of the literature [version 1; referees: awaiting peer review]

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Abstract

Morning Glory Syndrome (MGS) is a rare congenital malformation of the optic nerve that is caused by a failure of the closure of the choroidal embryonic fissure in utero. The syndrome is usually seen in association with midline cranial defects, such as transsphenoidal and basal encephaloceles. Although MGS usually presents as an isolated ocular finding, it can be associated with endocrinological abnormalities. We report a case of a 32 year old female with MGS with hyperprolactinemia and growth hormone (GH) deficiency. She was diagnosed with MGS at the age of three and her past medical history was significant for left eye blindness, hyperprolactinemia and GH deficiency. She has received GH replacement and oral contraceptive pills in the past. Our investigations revealed elevated prolactin levels (63mg/l) and borderline low GH levels. Magnetic resonance imaging revealed an abnormality involving the optic chiasm, left optic nerve and compression of the pituitary gland by a basal encephalocoele. Genetic studies were positive for a mutation in Paired box 6 gene (PAX6). She is being currently treated with cabergoline for her hyperprolactinemia. Our aims of this report are to highlight the hormonal manifestations of MGS and to review the etiopathogenesis of this rare disorder.

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Introduction

Morning Glory Syndrome (MGS) was first reported in German literature in 1929, but has been more frequently reported since Kindler named it in 1970. The name was based on the condition’s resemblance to the funnel-shaped excavation of the posterior fundus incorporating the optic nerve to a tropical morning glory flower. It is a rare congenital malformation of the optic nerve that is caused by a failure of the closure of the choroidal embryonic fissure in utero. We report a unique case of a 32 year old female with MGS with hyperprolactinemia and growth hormone (GH) deficiency. Our case highlights the various endocrinological presentations that can present concomitantly with this rare syndrome.

Case report

A 32 year old woman came to our clinic for the evaluation of amenorrhea and hyperprolactinemia. MGS was diagnosed at the age of 3 and at the age of 17 she was diagnosed with hyperprolactinemia and GH deficiency causing her to have a short stature (4 ft 1 inch). She had no family history of similar or related issues. She was treated with GH replacement in the past, which led to an increase in her height (5 ft) and she received oral contraceptives until the age of 28. Due to hyperprolactinemia and anovulatory cycles, she was treated with cabergoline. At the age of 31, she delivered a healthy baby via in vitro fertilization.

Her most recent physical and vital parameters were under normal limits (blood pressure: 110/70 mmHg; pulse: 72 per minute; height: five feet; weight: 126 pounds). Visual acuity to finger counting was 20/20 in the right eye and 20/200 in the left eye. She had hypertelorism and strabismus of the left eye. Laboratory investigations revealed: fasting glucose levels: 87 mg/dl (65–99); Prolactin: 62 ng/ml (2–14); GH: 0.2 ng/ml (0.0–10.0); GH arginine stimulation test: <2 ng/ml; Insulin-like growth factor 1: 22 ng/ml (0.58–1.6); Dehydroepiandrosterone: 323 ng/dl (125–166.0); Estradiol: 8.6 pg/ml (12.5–166.0); Estradiol: 323 ng/dl (31–701); adrenocorticotropic hormone: 83.1 pg/ml (7.2–63.3); thyroid stimulating hormone: 1.48 mIU/L (0.45–4.5); free T4: 1.2 ng/dl (0.58–1.6).

Magnetic resonance imaging (MRI) performed at this time revealed an abnormality involving the optic chiasm, left optic nerve and mild compression of the pituitary gland by a basal encephalocele (BE), with a normal sized pituitary gland. Genetic studies were positive for a mutation in Paired box 6 gene (PAX6). Magnetic resonance imaging (MRI) at this time revealed an abnormality involving the optic chiasm, left optic nerve and mild compression of the pituitary gland by a basal encephalocele (BE), with a normal sized pituitary gland. Genetic studies were positive for a mutation in Paired box 6 gene (PAX6). She continues to receive 0.5 mg of cabergoline once daily in view of her elevated prolactin levels. Our patient does not have any other symptoms and is being followed up regularly at our clinic.

Discussion

MGS is a rare congenital malformation of the optic nerve that is caused by a failure of the closure of the choroidal embryonic fissure in utero. It is characterized by an enlarged, funnel shaped optic disk with a central mass of white glial tissue, surrounded by a raised pigmented chorioretinal ring. MGS usually presents as a unilateral malformation without gender predisposition with a median diagnosis of two years. The pathogenesis of MGS is relatively unknown and studies are currently being done to understand the syndrome clearly.

MGS usually presents as an isolated ocular manifestation with decreased visual acuity, strabismus, myopia and astigmatism. The most common visual field defect is a central scotoma and MGS is also commonly associated with midline cranial defects, such as transsphenoidal and basal encephaloceles. Transsphenoidal encephalocele or BE have been largely associated with MGS, with 67% of people with BE also having MGS.

Cranial defects may present with wide heads, flat noses, cleft lip/palate, hypertelorism, agenesis of the corpus callosum, hypopituitarism, posterior pituitary ectopia, basal and transsphenoidal encephaloceles. BE is a herniation of tissue through the sphenoid bone or cribiform plate of the ethmoid bone. BE may present as a mass in the pharynx, nasal cavity and orbits. Literature suggests that the association of MGS with craniofacial abnormalities may be linked to an embryogenic effect. Kissel et al. theorized that defects in neural crest cells are responsible for the craniofacial malformations. This is the most probable mechanism by which BE occurs, due to the failure of closure of the anterior neuropore, which normally occurs by 4 weeks in utero. The embryological findings support the neurologic and craniofacial manifestations seen with MGS.

Hormonal dysfunctions are seen with approximately 50–60% of BE patients. GH deficiency (66.7%), hypogonadotropic hypogonadism, hypothyroidism, hyperprolactinemia (13.3%) and diabetes insipidus are the most common hormonal disorders reported. Eustis et al. postulated that the dysplastic optic discs in association with endocrine abnormalities are products of reduced trophic stimulation of the pituitary gland caused by abnormal hypothalamic control or an abnormal portal hypophysial system. Table 1 lists several cases of MGS associated with endocrinopathies that have been reported in literature.

Studies by Asakura et al. suggest that MGS may be associated with a heterozygous Prokineticin receptor 2 (PROKR2) gene mutation. The PROKR2 pathway plays a vital role in early pituitary development and the development of gonadotropin releasing hormone neurons. This could possibly explain the pituitary malformation and the hormonal imbalance seen in our case report. Hormonal disorders are common in patients with BE induced MGS, possibly due to malformed cranial structures, which exert pressure on the pituitary gland causing gland compression, thereby restricting production of hormones, such as GH and prolactin at healthy rates.

Genetic studies performed on our patient revealed a mutation in the PAX6 gene. PAX6 gene mutations are commonly implicated in congenital ocular malformations. PAX6 gene is responsible for activating genes involved in the formation of the eyes, brain, spinal cord, and pancreas during embryonic development. As far as MGS is concerned, the PAX6 protein is an excellent resource to study in patients, as it is responsible for ocular embryogenesis and regulating the expression of other genes involved in the other structures of the eye.
Table 1. Cases of Morning Glory Syndrome associated with different endocrinopathies that have been reported in the literature. Abbreviations: M: Male, F: Female, ADH: Anti-Diuretic Hormone, GH: Growth Hormone, TSH: Thyroid Stimulating Hormone, PRL: Prolactin, LH: Luteinizing Hormone, NP: Not Performed.

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Age (year)</th>
<th>Sex</th>
<th>Endocrine abnormalities</th>
<th>Optic abnormalities</th>
<th>Follow up</th>
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<tr>
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<td>21m</td>
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<tr>
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<td>M</td>
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<td>Present case</td>
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<td>F</td>
<td>GH, PRL</td>
<td>GH, PRL, LH</td>
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</table>

MGS is a complex disease, but can be diagnosed best through a fundus examination and radiological studies, such as CT scans and cranial MRI scans. The white glial tissue mass in the malformation causes the pupil to look a whitish-color (leukokoria), which is a classic and telling symptom. The diagnostic measures should be accompanied by a complete physical and ophthalmological examination and appropriate laboratory investigations to rule out hormonal dysfunction.

There are still under 100 cases of MGS reported worldwide. It is still a very rare medical anomaly that has not been greatly researched until more recent decades. Treatments are directed towards preventing and treating possible existing complications associated with the syndrome such as hormone replacement for hormonal imbalance and suitable correction lenses for myopia and astigmatism.

Conclusion
Our case aims to highlight the endocrinological manifestations of MGS. Although the association of MGS with pituitary hormonal imbalance is relatively well known, the diagnosis was established much later in our case. Early recognition of these features through physical examination and lab investigations should prompt appropriate intervention.

Consent statement
Written informed consent was obtained from the patient for the publication of the patient’s details.

Competing interests
No competing interests were disclosed.

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