

typical visual field defects seen in some of these patients with reported papilledema suggest that the impression made by junior residents was false.

The reported incidence of cranial nerve palsies other than the optic nerve is 5-17%. Usually the 3rd, 4th 6th and less commonly the 5th nerves are involved^[11-13]. Generally cranial nerve palsies suggest lateral extension into the cavernous sinus, and is mostly associated with aggressive adenomas. The 4 patients who had cranial nerve palsies (7.2%) all had lateral extension and all were aggressive tumors.

Regarding epilepsy, seizures were reported in 1-10% of patients with pituitary adenoma. Most series^[11,12,20] in this study it was noticed in one patient (1.8%), We could find no reason or association between epilepsy and the pathology or extension of the tumor.

Hypopituitarism, according to many series, was seen in a good proportion of patients. One important feature for example is Insufficient gonadotropic hormone secretion, which was found in 50-90% of patients (Bakay, 1950 and Arafah et al., 1986)^[11,21] In this study only one patient was diagnosed to have hypogonadism due to deficient gonadotropic hormone (GnH) secretion, confirmed by hormonal assessment (1.8%). This lowly incidence of hypogonadism in males, is probably only apparent, due to denial of patient for social reasons, and failure on the part of physicians to assess this important clinical feature of pituitary adenomas.

Regarding functional pituitary adenoma, we found that hyperprolactinemia comprises 72% (32% from total number), by comparing our results with those of other studies (Visot et al., 2001, Davis et al., 1985 and Kleinberg, 1983)^[22-24]. We found prolactin secreting adenomas comprising 25%. From this we expect that the higher percentage was not due to pure PRL

producing adenoma rather than secondary hyperprolactinoma due to local mass effects causing amenorrhea - galactorrhea Syndrome primarily in females and loss of libido with impotence in males.

Growth hormone (GH) secreting adenoma detected in 64% of patients with functioning pituitary adenomas (29% from total) in which acromegalic features detected in all of them, whereas gigantism detected in only one patient (4%), which is exactly the same percentage found in other series. Insulin dependent diabetes mellitus (IDDM) detected in 62% of patients with Acromegaly, Compared with about 50% reported in literatures. Hypertension detected (37.5%) similar with other studies 36% (Jackson et al., 1999)^[25].

Cushing's disease was found in 4% of functioning pituitary adenomas (1.8% from total), which is almost the same of other series (Tindall et al., 1985 and Sheithauer et al., 1986)^[2,26]. This disease is rare, and because most of them are due to a microadenoma (80%) it rarely gives rise to other hormonal or compression symptoms.

In our study, no patient was found to have hyperthyroidism or excessive secretion of GnH, which indicate their rarity as seen in other series, TSH producing adenoma comprising about 1% (Martin et al., 1977, Black et al., 1984, Linfoot et al., 1979, and Post et al. 1980)^[13,27-29].

Radiological investigations

The radiology of the sella tursica is an interesting subject when considering pituitary adenomas, in plane x-ray, non-functional pituitary adenoma enlarge the sella almost without exception. We had three patients in our study that had normal sized sella tursica (5.5%). With high resolution Brain CT scan, microadenomas can be correctly identified in 70% of cases, and the CT scanner was accurate in the detection of macroadenomas in 95% of cases. (Chang et al., 2000)^[19], most of which highly enhances with contrast study.