BLURRING ENDOCRINE BOUNDARIES: ACROMEGALY COEXISTING WITH PHEOCHROMOCYTOMA SUGGESTING AN ATYPICAL MEN OVERLAP.

TAZKIA NUR[1], NUR NAHAR BEGOM[2], HURJAHAN BANU[3]

Acromegaly is most commonly caused by a sporadic growth hormone secreting pituitary neuroendocrine tumor, with a minority occurring in hereditary syndromes such as multiple endocrine neoplasia type 1 (MEN1). In contrast, pheochromocytoma is a catecholamine-secreting tumor typically associated with MEN2A, von Hippel–Lindau disease, and related genetic conditions, and is rarely seen in MEN1(less than 1-2%).The coexistence of these two conditions is exceptionally uncommon. We report a 35-year-old woman diagnosed with acromegaly based on characteristic clinical features, elevated GH, and a pituitary macroadenoma on MRI. She underwent trans-sphenoidal resection in 2017 with biochemical remission and normalization of blood pressure. After approximately three years of stability, she developed recurrent hypertension, including an episode of accelerated hypertension, associated with headache, palpitations, tremor, and sweating. Suspected recurrence of acromegaly was excluded by normal IGF-1 levels and appropriate GH suppression. Given the adrenergic symptom pattern, 24hour urinary catecholamines were markedly elevated. Abdominal CT revealed a right adrenal mass consistent with pheochromocytoma. She underwent preoperative á- and â-blockade followed by successful laparoscopic adrenalectomy, with resolution of symptoms and normalization of catecholamine levels. This case highlights a key diagnostic pitfall in which pheochromocytoma may mimic recurrence of acromegaly. The discordant coexistence of pituitary adenoma and pheochromocytoma suggests either coincidental dual pathology or an atypical genetic syndrome. Clinicians should avoid diagnostic anchoring and ensure biochemical confirmation before attributing new symptoms to disease relapse. Comprehensive germline genetic testing, including RET, MEN1, CDKN1B, and SDHx analysis, is important to clarify the underlying etiology and guide both surveillance and family counseling, even in the absence of classical MEN features. Adrenergic paroxysms in treated acromegaly warrant prompt evaluation for pheochromocytoma. Systematic endocrine reassessment and genetic evaluation are essential for accurate diagnosis.

Keywords: Acromegaly, Pheochromocytoma, MEN syndrome.

Date of submission: *11.04.2026*

Date of acceptance: *30.04.2026*

DOI: *https://doi.org/10.3329/bjm.v37i20.89378*

Citation: *Nur T, Begom NN, Banu H. Blurring Endocrine Boundaries: Acromegaly Coexisting with Pheochromocytoma Suggesting an Atypical MEN Overlap. Bangladesh J Medicine* 2026; Vol. 37, No. 2(1): pp. *235.*

Affiliations:

1. *MD Resident, Department of Endocrinology, Bangladesh Medical University (BMU), Dhaka-1000, Bangladesh.*
2. *MD Resident, Department of Endocrinology, Bangladesh Medical University (BMU), Dhaka-1000, Bangladesh.*
3. *Associate Professor, Department of Endocrinology, Bangladesh Medical University (BMU), Dhaka-1000, Bangladesh.*