Letter to the Editor

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Letter to the Editor on the article entitled, *'Perioperative Complications Associated with Routine Preoperative Glucocorticoid Use Among Patients Undergoing Pituitary Surgery with Normal Preoperative HPA Axis: A Retrospective Cohort Study,'* by Magnaye and Paz-Pacheco, published in JAFES Vol. 40. No. 1.

Eisha Fatimah,[1] Sarosh Usman,[1] Muhammad Aqib Farooq Khan[2]

[1]*Quaid-e-Azam Medical College, Bahawalpur, Pakistan*
[2]*Islamic International Medical College, Riphah International University, Rawalpindi, Pakistan*

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This letter addresses the recent study by Magnaye et al., which investigated the impact of routine preoperative glucocorticoid administration in patients with a normal hypothalamic-pituitary-adrenal (HPA) axis undergoing pituitary surgery. The authors are commended for their valuable contribution to understanding steroid-related perioperative outcomes. However, we highlight the need for further clarification regarding the wide range of steroid regimens reported and the absence of detailed information on timing, indications, and factors influencing steroid administration. Additionally, differentiating between transient and permanent postoperative diabetes insipidus could provide deeper insight into the observed higher incidence among steroid-treated patients. Addressing these aspects, along with establishing standardized steroid protocols, could enhance the specificity and clinical applicability of the study's findings.

I recently came across this study by Magnaye et al.,[1] in which the authors have done a commendable job in addressing a clinically important topic, i.e., whether the routine administration of preoperative glucocorticoids in patients undergoing pituitary surgery with a normal hypothalamic-pituitary-adrenal (HPA) axis is actually beneficial in decreasing the rate of perioperative complications such as diabetes insipidus and postoperative infections. The study has done a great job of comparing the effects of steroid vs. non-steroid administration. The important findings highlighted by the authors provide significant and valuable points that shed light on this topic in a very detailed way.

The authors' work is commendable. However, we would like to bring to the authors' attention to some points. The authors have provided a wide range of regimens (mean hydrocortisone equivalent ≈ 142 mg/day, range 50–583 mg/day). In this case, a proper breakdown about timing and any additional indications or factors influencing the decision of steroid administration could have better explained patients having a higher risk of developing complications.[2] Also, the authors have reported a higher incidence of post-operative diabetes insipidus in patients given preoperative steroids (52.5% vs 28.2%, p = 0.006), but specifying the type of diabetes insipidus (permanent or transient) could maybe clear some doubts regarding the underlying cause. Transient diabetes insipidus is often seen after pituitary surgery and could have other causative factors, so the differentiation could have led to other potential causes being identified.[3]

In summary, this study by Magnaye et al., has raised valid concerns regarding the increased risk of certain post-operative infections in patients given steroids pre-operatively. It is truly commendable and provides a good insight into avoiding complications that could arise as a result of unnecessary steroid administration. However, mentioning the above points could add a touch of more specificity to the study. Discussing standardized steroid protocols that support the steroid sparing strategy and specifying the type of diabetes insipidus would help enhance the understanding of outcomes.

References

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Corresponding author: Eisha Fatimah, MBBS
Quaid-e-Azam Medical College, Bahawalpur Cantt,
Bahawalpur, 63100, Pakistan
E-mail: dr.eishafatimah96@gmail.com
ORCiD: https://orcid.org/0009-0001-5380-0066

RESPONSE OF THE AUTHORS

The authors appreciate the questions raised in relation to the paper "Perioperative complications associated with routine preoperative glucocorticoid use among patients undergoing pituitary surgery with normal preoperative HPA axis: a retrospective cohort study."

We are pleased to know that readers value the issues related to this important clinical condition. In response to the points raised, indeed, these are critical factors that can provide more clarity to the relationship between preoperative steroid use and perioperative outcomes. As described, this was a retrospective study that relied on available data on patients' medical records.

Ascertainment of detailed information on timing, indications and other factors determining choice for steroid administration was limited. Determination of transient versus permanent diabetes insipidus was not specified. Thus, as stated in the paper, it is recommended that a prospective study be carried out with a randomized controlled trial (RCT) design in a larger group of patients. Thereafter, a consensus can be developed and further discussed.

Franz Michael Magnaye and Elizabeth Paz-Pacheco