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ISOLATED ADRENOCORTICOTROPHIC HORMONE DEFICIENCY SECONDARY TO ANTI PROGRAMMED DEATH-1 IMMUNE CHECKPOINT INHIBITOR

https://doi.org/10.15605/jafes.036.S39

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INTRODUCTION

Immune-checkpoint inhibitors (ICI) are a novel class of drugs for the treatment of many advanced solid tumor and hematological malignancies. They produce durable anti-tumor responses, but they are also associated with immune-related adverse events (irAE). Endocrinopathies are one of the most common irAE of ICI with a reported incidence ranging from 15 to 90% in late-phase clinical studies.

RESULTS

A 70-year-old female with advanced adenocarcinoma of the lung who received six cycles of Pembrolizumab was admitted with persistent nausea, dizziness and generalized weakness. There was no headache or disturbance in the visual field. There was no diarrhea, loss of weight, abdominal pain, or galactorrhea. Laboratory analyses showed low serum sodium. She improved on saline hydration, yet her sodium levels remained low in the outpatient visits. Hence, a thorough pituitary hormone panel then revealed low serum cortisol and adrenocorticotrophic hormone (ACTH) and raised serum prolactin. Thyroid function test, insulin-like growth factor-1, and sex hormones were within normal limits. Brain MRI showed a pituitary incidentaloma measuring 4 mm x 5 mm. The patient was diagnosed with isolated ACTH deficiency secondary to ICI therapy. She responded to oral hydrocortisone replacement with normalization of serum sodium level.

CONCLUSION

As ICI are now used to treat many cancers, clinicians should be aware of the potential risks of endocrine dysfunction. Single or multiple hormonal deficiencies may occur. Onset is usually after two to six months from initiation of ICI therapy. Patients may present with nonspecific symptoms such as dizziness and lethargy. Key concepts of management include high index of clinical suspicion, appropriate localization of endocrine dysfunction, replacement of hormones and close monitoring. Immune-related endocrine events are unique as the manifestations are often irreversible and management requires lifelong hormone replacement.

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PRIMARY ADRENAL LYMPHOMA AS AN AETIOLOGY OF FLUCTUATING BILATERAL ADRENAL MASSES

https://doi.org/10.15605/jafes.036.S40

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INTRODUCTION

Primary adrenal lymphoma (PAL) is rare, with fewer than 200 reported cases. They usually present with bilateral adrenal masses affecting elderly males, with diffuse large B cell lymphoma as the most common subtype (78%).

RESULTS

We describe the case of a 60-year-old woman with severe right flank pain for three days. She denied any constitutional and B symptoms, and any tuberculosis contacts. There were no headaches, palpitations or hypertensive episodes. Ultrasound followed by computed tomography (CT) of the abdomen demonstrated a large right suprarenal (8 cm x 5.7 cm x 7.3 cm) and a small enhancing left adrenal mass (1.1 cm x 1.3 cm x 2.3 cm). Urine metanephrines, aldosterone:renin ratio, dehydroepiandrosterone and overnight dexamethasone suppression test were normal. A repeat CT three months later showed size reduction in the right suprarenal (3.4 cm x 3.2 cm x 3.4 cm) and increase in the left suprarenal mass (2.9 cm x 3.7 cm x 3.8 cm). Both were heterogeneously enhanced (39 and 36 HU, absolute contrast washout 39% and 31%, respectively). One month later, there was further decline in size of the right suprarenal (2.2 cm x 2.3 cm x 2.5 cm) and completely resolved left suprarenal mass on abdominal sonography. She denied taking any steroid-containing medication. Two months afterward, she presented with symptom recurrence. Repeat CT adrenal protocol showed large masses arising from both adrenal glands (8.5 cm x 5.9 cm x 7.6 cm and 5.0 cm x 3.2 cm x 3.8 cm, respectively). Endoscopic ultrasound-guided fine needle biopsy of the left adrenal revealed high-grade diffuse large B-cell lymphoma. She was referred to haematology for chemotherapy.

CONCLUSION

PAL must be considered as one of the differentials of bilateral adrenal masses. Size fluctuation and rapid progression were not associated with any systemic symptoms.