CONCLUSION
There were significant changes in weight and other clinical metabolic parameters with personalised lifestyle changes given through a structured weight management programme. These changes can be seen as early as 6 months and extends to 12 months. This correlates with current evidence that lifestyle changes require a minimum of 6 months' duration to achieve meaningful metabolic results.

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THYROXINE ABSORPTION TEST: A CASE SERIES OF PATIENTS WITH PERSISTENT PRIMARY HYPOTHYROIDISM

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INTRODUCTION
Persistent primary hypothyroidism of any etiology despite high doses of levothyroxine replacement is a common encounter in our clinical practice. It is important to distinguish nonadherence (pseudo-malabsorption) from malabsorption. Thyroxine absorption test is required to make this distinction before further evaluations for malabsorption. We present our review on our institution's experience with thyroxine absorption test and evaluate its role and clinical impact on management of persistent primary hypothyroidism.

RESULTS
All 5 patients tolerated the absorption test well and showed >100% rise in Free T4 level at the fourth hour. During subsequent visits, 4 out of 5 patients were able to achieve normal thyroid function with the same, if not, a lower dose of levothyroxine. Two patients continued to show fluctuations in TSH trend during follow-ups. There were discrepancies in the test protocol on levothyroxine dosage and sampling time.

CONCLUSION
Thyroxine absorption test is a useful tool to distinguish between nonadherence and malabsorption. It negates unnecessary extensive search for causes of malabsorption. It provides objective information to guide discussions between clinicians and patients in addressing the issue of nonadherence.

PP-29

PRIMARY ALDOSTERONISM UNVEILED BY PREGNANCY

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INTRODUCTION
Primary aldosteronism (PA) with first presentation during pregnancy is rare. We hereby report 2 cases of PA which was unveiled by pregnancy.

RESULTS
Case 1: A 33-year-old female was diagnosed to have hypertension with hypokalaemia (lowest serum potassium of 2.3mmol/L) during early pregnancy. The pregnancy was complicated by intrauterine death at 29 weeks of gestation. Throughout pregnancy, her blood pressure (BP) and potassium levels were well-controlled with low-dose methyldopa` and potassium supplementation. Postpartum, she was normokalaemic without potassium supplementation and her BP was well-controlled with low-dose verapamil. She had a positive screening test for PA which was further confirmed with fludrocortisone suppression test (FST). Computed Tomography (CT) of the adrenal glands showed bulky appearance with no definite adenoma. Adrenal venous sampling (AVS) was suggestive of bilateral adrenal hyperplasia (BAH). Spironolactone was not started as she is planning for another pregnancy. To date, her BP was well-controlled with low-dose labetolol and she remained normokalaemic.

Case 2: A 40-year-old female was diagnosed to have hypertension at 18 weeks of gestation with concomitant hypokalaemia (lowest serum potassium of 3.3mmol/L). Throughout pregnancy (while not on any medications) her BP ranged between 130/90 to 150/90 and serum potassium levels between 3.5 to 3.8 mmol/L. She underwent emergency caesarean section for pre-eclampsia at 36 weeks of gestation. Postpartum ambulatory blood pressure monitoring revealed SBP of 111-158 mmHg, DBP of 64-102 mmHg. Her screening test for PA was positive and was further confirmed with fludrocortisone suppression test. CT adrenals showed bulky appearance with no definite adenoma. AVS was suggestive of BAH. Upon commencement of spironolactone 12.5 mg daily, her BP was maintained at 110/80-128/90 mmHg and serum potassium was 4.0mmol/L.

CONCLUSION
PA is associated with high rate of pregnancy-related complications. The course of PA during pregnancy is highly variable owing to the sequential changes in the renin-angiotensin-aldosterone system and plasma progesterone concentration.