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RECURRENT CEREBROVASCULAR EVENTS FOLLOWING EPISODES OF GRAVES' THYROTOXICOSIS IN A PATIENT WITH MOYAMOYA DISEASE

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Tivya S, N Sukor, NA Kamaruddin
Endocrine Unit, Universiti Kebangsaan Malaysia Medical Centre (UKMMC), Kuala Lumpur, Malaysia.

INTRODUCTION
Moyamoya disease is a cerebrovascular disease characterised by progressive stenosis of the intracranial internal carotid arteries and their proximal branches that predisposes patients to cerebrovascular accidents. To date, at least 20 cases of Moyamoya disease have been reported in patients with Graves' disease (GD). As a result, episodes of thyrotoxicosis have been known to trigger cerebrovascular events [2]. Therefore, prompt control of thyrotoxicosis is of paramount importance as it reduces the incidence of cerebrovascular accidents (CVA) and transient ischaemic attacks (TIA) while waiting for definitive surgery for Moyamoya disease. We hereby report a case of recurrent cerebrovascular events in a patient with Moyamoya disease that coincided with episodes of thyrotoxicosis following the diagnosis of GD.

RESULTS
A 25-year-old woman diagnosed with Graves' disease presented with recurrent episodes of transient ischemic attacks (TIA) and cerebrovascular accidents (CVA) over the course of 3 years. Each episode was precipitated by relapsed thyrotoxicosis following non-compliance to antithyroid therapy. The patient complained of thyrotoxic symptoms during each TIA and CVA presentations. Repeated CT scans of the brain revealed multiple cerebral infarctions in the right frontal and parietal lobes. Both cerebral magnetic resonance angiography and angiogram revealed small calibre intracranial internal carotid arteries, middle cerebral arteries and external carotid arteries with stenosis of bilateral internal carotid arteries. These findings were consistent with Moyamoya vasculopathy. Finally, when the thyrotoxicosis was brought under control, she underwent a successful superficial temporal artery to middle cerebral artery (STA-MCA) bypass procedure. This highlights the importance of prompt control of thyrotoxicosis in preventing repeated cerebrovascular events.

CONCLUSION
Prompt control of thyrotoxicosis with the immediate administration of radioiodine or by undergoing total thyroidectomy is essential as relapses of thyrotoxicosis often trigger repeated cerebrovascular accidents and transient ischaemic attacks.

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A SINGLE CENTRE 20 YEARS' EXPERIENCE AND OUTCOME OF BILATERAL ADRENALECTOMY

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Siti Sanaa WA,[1] Zanariah H,[1] Anita B[2]
[1]*Endocrine Unit, Department of Medicine, Hospital Putrajaya, Malaysia*
[2]*Surgical Department, Hospital Putrajaya, Malaysia*

INTRODUCTION
Bilateral adrenalectomy is an extremely rare operation performed due to its limited indications. Only 1-6% of patients undergoing adrenal surgery needed a bilateral procedure.

METHODOLOGY
This is a retrospective medical records review of all patients who underwent bilateral adrenalectomy from 2000 to 2020.

RESULTS
Between 2000-2020, a total of 22 patients (5 male, 17 female) underwent bilateral adrenalectomy, simultaneous procedure was performed for sixteen patients while the remaining had sequential adrenalectomy at an interval of 7 months-12 years from the first surgery. Mean age was 38.2 years (range 21-72), mean duration of follow-up was 66 months (range 1-252 months). Two patients died at 3 and 10 months post-surgery due to sepsis. The indications for surgery were bilateral pheochromocytoma in 59% (n=13) of which six patients were MEN2A-associated, and one with SDHD-related disease. Eight patients (36%) had Cushing's syndrome (CS) of which half were ectopic CS (ECS) (3 malignant mediastinal NET, one unlocalised ECS), one patient with refractory Cushing's Disease and three with CS due to bilateral adrenal pathology which comprised of two patients with primary pigmented nodular adrenocortical disease (PPNAD) as part of Carney Complex, and one patient with ACTH-independent macronodular adrenocortical hyperplasia (AIMAH). There was a single case of primary aldosteronism due to bilateral adrenal hyperplasia with refractory hypertension. This patient underwent sequential adrenalectomy. Five patients (22.7%) underwent adrenal sparing surgery but adrenocortical function was preserved in only two patients. 91% were maintained on physiological replacement doses of hydrocortisone 15–20 mg in two to three divided doses and seven (32%) patients required concomitant fludrocortisone replacement at a dose of 0.05–0.1 mg daily.

CONCLUSION
Bilateral adrenalectomy is advocated in a small population of patients, and adrenal sparing surgery may be considered in a subgroup of patients with familial pheochromocytoma. Extra caution should be anticipated and exercised in patients with pre-existing severe uncontrolled hypercortisolaemic state.