CR-GE-23

AN AUTOIMMUNE POLYGLANDULAR SYNDROME TYPE II PRESENTING WITH HASHIMOTO'S THYROIDITS, DIABETES MELLITUS AND ADRENAL INSUFFICIENCY: A CASE REPORT

https://doi.org/10.15605/jafes.034.02.S116

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INTRODUCTION
Autoimmune Polyglandular Syndrome affects 2 or more endocrine glands. It is more commonly seen among females with a gender ratio of 3:1 and usually manifests at a peak age of between 20 and 60 years. Among the 3 subtypes, type 2 is the most frequent one, manifesting with autoimmune thyroiditis, Diabetes Melitus Type 1 and Addison's disease.

CASE
We report a 40-year-old male who presented with multiple concomitant endocrine abnormalities. Physical and laboratory examinations revealed hyperthyroidism, diabetes mellitus and adrenal insufficiency. He was initially diagnosed with hyperthyroidism which eventually converted to hypothyroidism most likely Hashimoto's thyroiditis, as evidenced by high TSH levels even after 1 month of discontinuing antithyroid medication. He was also discovered to have diabetes mellitus type 1 after initially being admitted for diabetic ketoacidosis. During his most recent admission for acute gastroenteritis, he came in hypotensive. ACTH stimulation test result was compatible with adrenocortical insufficiency.

CONCLUSION
A prompt diagnosis can prevent mortality and morbidity with this kind of syndrome. This can be treated individually by hormonal therapy.

KEY WORDS
autoimmune polyglandular syndrome type 2, autoimmune thyroiditis, Addison's disease

CR-GE-24

ASYMPTOMATIC PHEOCHROMOCYTOMA PRESENTING AS ADRENAL INCIDENTALOMA

https://doi.org/10.15605/jafes.034.02.S117

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INTRODUCTION
Adrenal incidentalomas remain a diagnostic dilemma for endocrinologists. Pheochromocytoma is the most critical of the differential diagnosis that needs to be ruled out because of its fatal consequences. More commonly symptomatic with elevations of blood pressure during spells of catecholamine secretion, a subset of patients has been reported with normal blood pressure. We present a clinically asymptomatic female that was evaluated for an incidental mass on her right adrenal.

CASE
A 32-year-old female consulted for a right adrenal mass noted on routine ultrasound for abdominal discomfort. She had no history of hypertension nor fluctuations of blood pressure up to initial evaluation. CT scan of abdomen with contrast showed a 3x4x3 cm right adrenal mass, with slow wash-out on delayed scan. She had elevated 24-hour urine metanephrine 1.96 mg/24 hrs (NV: 0-1), 24-hour urine epinephrine 129 mcg/24hrs (NV:2-24) and chromogranin A levels 225.38 ng/ml (NV:<100). 24-hour urine norepinephrine 84 mcg/24 hrs (NV 15-100) and dopamine 349 mcg/24 hrs (NV:52-480) were normal. Aldosterone-to-renin ratio was 56.21 (NV:<20 ng/dl per ng/ml/hr), with low renin 0.14 (NV:0.48-4.88 ng/ml/hr) and normal aldosterone 7.87 (NV:5.38-38.76 ng/dl). Luteinizing hormone 4.33 (NV:3.5-12.5 mIU/ml), follicle-stimulating hormone 3.21 (NV:<7 mIU/ml), estradiol 67.7 (NV:15-350 pg/ml). 8 am serum cortisol (28.28 nmol/L) was appropriately suppressed after overnight 1 mg dexamethasone. Alpha blocker and calcium channel blocker were given preoperatively. Laparoscopic adrenalectomy revealed a 4.5cm adrenal tumor. There were extreme fluctuations in blood pressure during tumor manipulation. Histopathology confirmed the pheochromocytoma.

CONCLUSION
Asymptomatic pheochromocytoma is a rare and potentially fatal finding in the background of adrenal incidentaloma. Proper diagnosis and perioperative management are essential for the successful removal of these tumors.

KEY WORDS
pheochromocytoma, asymptomatic, adrenal, mass, incidentaloma