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MALIGNANT STRUMA OVARII IN PREGNANCY

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INTRODUCTION

Struma ovarii is monodermal teratoma predominantly composed of mature thyroid tissue. Thyroid tissue must comprise more than 50% of the overall tissue to be classified as a struma ovarii and it accounts for approximately 2.7-5% of all ovarian teratomas. Depending on the histological features, struma ovarii can be classified as benign or malignant.

CASE

We report a case of a 28-year-old Malay primigravida. She visited the antenatal clinic on her 9th gestational week. Ultrasound of the pelvic incidentally found a right ovarian cyst measuring 9 x 8 cm located above the uterus, which is multiloculated with solid-cystic component. Otherwise, she was asymptomatic at presentation. Patient underwent laparoscopic right ovarian cystectomy on her 13th gestational week. Histopathology examination revealed a mature cystic teratoma, with papillary thyroid carcinoma arising in the background of struma ovarii. She had subclinical hyperthyroidism at early pregnancy, however normalized at her 23rd gestational week. Subsequent thyroid ultrasound was normal.

She successfully delivered a healthy baby at her 38th gestational week. There was no evidence of metastasis based on the computed tomography (CT) scan of the thorax, abdomen, and pelvis. Six weeks after delivery, she underwent laparoscopic right salpingo-oophorectomy with omentectomy and right pelvic lymph node sampling which also showed no evidence of metastasis.

CONCLUSION

Struma ovarii is a rare ovarian tumour. A high index of clinical suspicion along with thorough clinical examination is crucial to diagnose such a tumour. Although benign forms are more common, malignant struma ovarii, mainly papillary thyroid carcinoma have also been reported. Long-term follow up is needed to detect recurrence.

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SEVERE HYPERCALCAEMIA OF HYPERPARATHYROIDISM WITH CARDIAC COMPROMISE; AVOIDING DIALYSIS WITH AGGRESSIVE MEDICAL THERAPY

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INTRODUCTION

Severe hypercalcaemia of primary hyperparathyroidism (pHPT) is usually symptomatic and carries high mortality risk due to cardiac arrhythmia and decompensation. Treatment involves vigorous hydration alongside anti-resorptive agents such as bisphosphonate and RANK-Ligand inhibitor i.e., denosumab. Usually, serum calcium of more than 4 mmol/l necessitates dialysis. Here, we report a case of severe hypercalcaemia of hyperparathyroidism with cardiac compromise treated medically resulting to avoidance of dialysis.

CASE

The case is a 50-year-old female with hypertension and chronic kidney disease stage IIIB who was diagnosed with primary hyperparathyroidism since 2020. She was stable with mild hypercalcaemia (calcium less than 3.0 mmol/L). During endocrine follow-up, she complained of constipation, abdominal discomfort, lethargy and vomiting for 2 weeks. She has no cough, no constitutional symptoms, no bone pain, no recent fracture or immobilisation and she denied taking any supplementations. Clinical assessment done was in keeping with severe dehydration.

Blood investigations revealed severe hypercalcaemia (5.01 mmol/L) with normal phosphate and acute azotemia (urea 11, Creatinine 191). Electrocardiography showed first degree heart block, with short QT interval, and a heart rate 60-80 bpm.

Hydration with 5 litres of normal saline and intravenous denosumab was given. Nephrology team was consulted, but no dialysis was planned. On the third day of admission, hydration was increased to 6 litres/day alongside intravenous furosemide to induce forced diuresis. Calcium level reduced to 3.1 mmol/L after a week of admission. Repeated ECG showed resolution of the heart block and short QT. Right inferior parathyroidectomy was done after localisation 2 weeks after. Histopathology confirmed parathyroid adenoma.