up period, there was no significant difference in the mean BP for both treatment groups however surgical group required a lesser number of anti-hypertensive medications (1.33 ± 0.86) as compared to the pharmacologic group (2.95 ± 0.73) (p <0.001).

CONCLUSION
Diagnosis of PA remains suboptimal leading to a high burden of aldosterone-specific end-organ damage. The majority of confirmed PAs received medical therapy either due to individual preference or lack of AVS-guided treatment. Patients who underwent surgery attained greater biochemical improvement and reduced medication burden in the long term.

KEYWORDS
hypertension, hypokalemia, primary aldosteronism, adrenal imaging, adrenal venous sampling

PP-A-03

CONGENITAL ADRENAL HYPERPLASIA MANIFESTING WITH AMBIGUOUS GENITALIA

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CASE
Congenital adrenal hyperplasia (CAH) is a group of autosomal recessive diseases caused by a deficiency of the enzymes responsible for steroidogenesis. The prevalence of the classical form is 1 in 14,000-18,000 births worldwide, while the non-classical form has a prevalence of 1 person per 200 in the US.

We report a 28-year-old Indonesian female with complaints of genital growth abnormalities, an incomplete vagina, and a small penis from birth. The patient carries out activities like a man and the penis can still be erect. Chromosomal analysis revealed intersex 46XX. Laboratory results were as follows: FSH 0.424 mIU/mL, LH <0.300 mIU/mL, estradiol (E2) 39 pg/mL, testosterone 6.01 ng/mL, cortisol 2.00 µg/dL, DHEA 1379.50 µg/dL and 17-OHP 258.05 ng/mL. Abdominal ultrasound showed uterine echostructure in the retrovesica. Abdominal MSCT showed bilateral enlargement of the adrenal glands and a visible uterine structure in the pelvic cavity.

The patient was diagnosed with CAH with ambiguous genitalia. The patient was treated with 20 mg oral hydrocortisone once daily and was advised to undergo adrenalectomy and genital reconstruction.

KEYWORDS
CAH, enzyme deficiency, ambiguous genitalia

PP-A-04

A RARE CASE OF AN ADRENOCORTICAL ADENOMA MANIFESTING WITH PERIODIC PARALYSIS IN A 39-YEAR-OLD WOMAN

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CASE
Periodic paralysis is a rare manifestation of primary hyperaldosteronism. This case demonstrates that primary hyperaldosteronism should be included in the differential diagnosis of periodic paralysis, especially in patients with hypertension. In this case, a 39-year-old Indonesian female was admitted to the hospital with the main complaint of a three-year history of recurring weakness of all four extremities. The patient said she was on therapy for hyperthyroidism and hypertension. Blood tests revealed potassium 1.6 mEq/L. A right adrenal tumor was discovered during a CT scan of the abdomen with contrast. The patient was then treated with a unilateral adrenalectomy. Histopathological examination which showed an adrenocortical adenoma. Primary hyperaldosteronism is caused by an aldosterone-producing adrenal adenoma. Patients may experience sporadic temporary paralysis due to severely low blood potassium levels. A CT scan or MRI can be utilized to diagnose the adenoma. The patient's condition progressively improved following the adrenalectomy.

KEYWORDS
adrenocortical adenoma, periodic paralysis, hypokalemia, adrenalectomy