PP-A-10

SPONTANEOUS BILATERAL ADRENAL HEMORRHAGE AS MANIFESTATION OF PRIMARY ANTIPHOSPHOLIPID ANTIBODY SYNDROME: A CASE REPORT

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Marivi Grace Mercado-Nerit
Chinese General Hospital and Medical Center, Manila, Philippines

CASE
A 31-year-old Filipino female presented with epigastric tenderness. She had anemia, thrombocytopenia, hyponatremia, and elevated D-dmer. An initial CT scan of the abdomen showed left adnexal fluid. Due to worsening of symptoms, a mesenteric CT angiogram was done revealing a left adrenal gland hematoma. Adrenal function was shown to be normal but she was started on hydrocortisone. An emergency adrenal angiogram was done revealing extravasation of dye from the inferior, superior, and middle adrenal arteries. A superselective adrenal arterial embolization was performed which resulted in a dramatic decrease in dye extravasation. Post-procedure, the patient developed a fever and dyspnea. On chest x-ray, there was a sudden increase in cardiac size. She was given a dose of methylprednisolone pulse therapy for possible SLE-related pericardial effusion. Blood specimen was sent for ANA, anti-DsDNA, and anti-cardiolipin studies revealing positive results. She eventually improved with tapering doses of prednisone and hydroxychloroquine.

KEYWORDS
adrenal hemorrhage, adrenal insufficiency, embolization, steroids, adrenal

PP-A-11

INCIDENTAL ERYTHROCYTOSIS AS THE FIRST MANIFESTATION OF CUSHING'S SYNDROME

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Marivi Grace Mercado-Nerit
Chinese General Hospital and Medical Center, Manila, Philippines

CASE
A 23-year-old Filipino female was consulted due to incidental erythrocytosis. Initial physical and laboratory examinations were unremarkable other than an elevated blood pressure. She was initially started on Telmisartan. In the interim, she noted a progressive increase in her weight and abdominal girth. She also developed hirsutism, buffalo hump, and abdominal purplish striae. Her blood pressure was persistently elevated, hence, her Telmisartan was increased to 80 mg/day, with the addition of Carvedilol 25 mg/day, Lercanidipine 20 mg/day, and Spironolactone 50 mg/day. Endocrine work-up showed dyslipidemia, diabetes, and hypercortisolism consistent with Cushing's Syndrome. Her upper abdominal CT scan revealed a left adrenal gland nodule. She subsequently underwent an open adrenalectomy with pancreatic tail excision due to mass adherence. She was given a stress dose of hydrocortisone prior to the procedure. The histopathologic report was consistent with adrenocortical adenoma. Postoperatively, her erythrocytosis resolved. Her blood pressure was controlled with carvedilol 50mg/day alone. She was discharged with tapering doses of prednisone and insulin.

KEYWORDS
endocrine hypertension, Cushing's syndrome, adrenal nodule, erythrocytosis, hypercortisolism

PP-A-12

CHROMOGRANIN-POSITIVE ALDOSTERONE-PRODUCING ADRENOCORTICAL CARCINOMA WITH CORTISOL CO-SECRETION: A CASE REPORT

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Megan Margrethe Balina
University of Santo Tomas Hospital, Manila, Philippines

CASE
A 45-year-old Filipino female consulted due to persistent bilateral lower-extremity weakness associated with poorly-controlled hypertension on triple anti-hypertensive medications, recurrent spontaneous hypokalemia, elevated plasma aldosterone concentration (PAC), suppressed plasma renin activity (PRA), elevated PAC/PRA ratio at 318.29 ng/dL per ng/mL/hour, and a nonsuppressed 8 am serum cortisol at 11.6 ug/dL after 1 mg overnight dexamethasone suppression test. A computed tomography scan of the abdomen (adrenal protocol) showed a heterogeneously enhancing right adrenal mass measuring 6.2 x 6.5 x 9.5 cm (previously 4.6 x 5.3 x 6.3 cm), exhibiting intralesional vascularity and areas of necrosis, with mass effect to the liver, right kidney, and inferior vena cava. She underwent an open right adrenalectomy with the removal of a 9.5 x 6.8 x 5.0 cm encapsulated mass. The histopathology report revealed a low-grade adrenocortical carcinoma.

KEYWORDS
adrenocortical carcinoma, aldosterone, cortisol, ACC, chromogranin-positive