PP-T-09

ALTERNATIVE LEVOTHYROXINE ADMINISTRATION VIA THE RECTAL ROUTE: A CASE REPORT

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CASE
Hypothyroidism is commonly replaced with oral levothyroxine, however, there are cases wherein the oral route may not be available or contraindicated, and parenteral preparations are not accessible. We report an alternative way of administering levothyroxine in a 70-year-old Filipino male diagnosed with post-surgical hypothyroidism. The accidental removal of the nasogastric tube served as a dilemma on how to continue levothyroxine replacement prior to gastrostomy tube insertion. With no definite guidelines, levothyroxine was prepared in a saline solution in increasing dosage via rectal enema. Serial-free T4 and T3 were measured until normalization just prior to surgery. High doses of levothyroxine enema proved as an alternative and effective way of managing hypothyroidism when the conventional route is contraindicated and parenteral preparations are not available. This case report however does not recommend rectal administration over the oral route, but this can be a useful guide for future cases that may require levothyroxine administration via the rectal route.

KEYWORDS
levothyroxine, hypothyroidism, rectal enema

PP-T-10

A 31-YEAR-OLD MAN WITH GRAVES' DISEASE, EVAN'S SYNDROME AND IMPAIRED LIVER FUNCTION

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CASE
Graves' disease (GD) is an autoimmune disease of the thyroid gland and is the most prevalent cause of hyperthyroidism. Autoimmune hemolytic anemia (AIHA) in GD can appear alone or together with Immune thrombocytopenic purpura (ITP), as part of Evan's syndrome (ES).

We report a case of Graves' Disease with Evan's Syndrome and Impaired Liver Function. A 31-year-old male was admitted due to weakness, palpitations, jaundice, and weight loss. Graves' disease was diagnosed based on existing clinical manifestations, with a total Wayne Index score of 26, elevated FT4, decreased TSH, and positive Thyrotropin Receptor Antibody (TRAb). ES in this patient was based on laboratory results of anemia, thrombocytopenia, reticulocytosis, hyperbilirubinemia, and positive direct antiglobulin test (DAT). The patient was considered to have secondary, rather than primary ES because it was suspected to be caused by GD as an autoimmune disease. He was given thyrozole, propranolol, Kalium Slow Release (KSR), methylprednisolone, and Ursodeoxycholic Acid (UDCA) for impaired liver function. In summary, we reported a 31-year-old male with GD, hematological abnormalities, and impaired liver function. The patient was treated for two weeks and with clinical and laboratory improvements after administering antithyroid, steroid, and UDCA therapy.

KEYWORDS
Graves' disease, autoimmune hemolytic anemia, Evan's syndrome

PP-T-11

A RARE CASE OF MYXEDEMA COMA IN A CRITICALLY ILL PATIENT WITH SEPTIC SHOCK: A CASE REPORT

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CASE
Myxedema coma is a rare and life-threatening disorder of hypothyroidism occurring in 0.22 per 1 million people per year diagnosed clinically. We report an 87-year-old female, known to have non-ischemic dilated cardiomyopathy, and COPD, presenting with a 2-day history of colds progressing to desaturations at room air. At the ER, was only responsive to vigorous tapping, without spontaneous movement of extremities and eye-opening prompting intubation. At the ER, capillary blood glucose was unreadably low, and hypotensive hence started on vasopressors and inotropes. Laboratory tests showed hyponatremia (129 meqs/L), elevated Creatinine (1.3 mg/dl), an elevated TSH (56.61 uIU/ml), and low FT4 (0.29 ng/dl) and FT3 (1.00 pg/ml). We started loading doses of Levothyroxine per orem and per rectum and Liothyronine, as IV Levothyroxine was not available, however, succumbed to her disease on the 1st day of admission. Prompt treatment and recognition of myxedema coma should be done to prevent mortality in this rare disorder.

KEYWORDS
myxedema coma, hypothyroidism, septic shock, thyroid, thyroid stimulating hormone