appendix with base of appendix involvement. Contrast-enhanced CT showed suspicious nodule in both upper and lower lobes of the lungs. Gallium dotatate PET Scan showed no dotatate-avid lesions in the bowels, lymph nodes and lung metastases. Due to involvement of appendiceal base, a decision of hemicolectomy was made. Histopathology showed no evidence of tumour involvement in bowel.

CONCLUSION
Although ANETs are usually benign, non-functional and have good prognosis, it is important to identify features needing further anatomical and functional imaging which would determine whether right hemicolectomy is needed to prevent metastases or recurrence.

EP_A047

PEMBROLIZUMAB-INDUCED HYPOPHISITIS IN A PATIENT WITH UNDERLYING HYPOTHYROIDISM PRESENTING AS ADRENAL CRISIS: A CASE REPORT

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Abdullah Shamshir Abd Mokti[1] and Raja Nurazni Raja Azwan[2]
[1]*Endocrine Unit, Medical Department, Hospital Selayang, Malaysia*
[2]*Endocrine Unit, Medical Department, Hospital Tengku Ampuan Afzan, Kuantan, Malaysia*

INTRODUCTION/BACKGROUND
Pembrolizumab is a checkpoint inhibitor recently used to treat various types of malignancies. It is an analogue of programme-cell-death-1 (PD1) protein analogue involving immune T-cells and has been shown to cause immune-related adverse events including endocrinopathies. Most reports related to pembrolizumab were on thyroiditis.

We report a case of a patient presenting with adrenal crisis due to hypophisitis after after he was started on treatment with pembrolizumab.

CASE
A 73-year-old female with underlying hypothyroidism and hepatitis-B was diagnosed in 2019 with hepatocellular carcinoma stage C (T2N1M0). Post-lobectomy with lymph-node clearance, she was started on pembrolizumab and planned for 28 cycles. She presented to casualty department after the fourth cycle of chemotherapy with vomiting, diarrhoea, abdominal discomfort and reduced oral intake. There was no hypotension or hypoglycaemia but she had hyponatraemia (Na:125 mmol/l) with normokalaemia. She was treated with intravenous fluid and discharged after 2 days. However, she presented 5 days later with hypotension, hypoglycaemia and severe hyponatraemia (Na: 117 mmol/l) and hyperkalaemia (K 5.8 mmol/l). She was diagnosed with an adrenal crisis and treated with intravenous hydrocortisone. Further hormonal workout revealed low serum cortisol (15 nmol/l) and undetectable ACTH due to hypophisitis. She made remarkable recovery and parenteral hydrocortisone was tapered and shifted to tablet.

CONCLUSION
High index of suspicion for hypophysitis and hormonal deficiencies in patients treated with pembrolizumab is vital to prevent delay in diagnosis of endocrine emergencies such as adrenal crisis. Furthermore, patients not previously diagnosed should be screened and periodically followed-up to detect hormonal deficiencies from treatment with immune checkpoint inhibitors.

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HYPONATREMIA AND TSHoma: THE ODD COUPLE

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Quan Hziung Lim, Nicholas Ken Yong Hee, Ken Seng Chiew, Marisa Khatijah Borhan, Katherine Khor, Ee Wen Loh, Tharsini Sarvanandan, Sharmila Paramasivam, Lee Ling Lim, Jeyakantha Ratnasingam, Siew Pheng Chan, Shireene Ratna Vethakkan
Endocrinology Unit, Department of Medicine, Universiti Malaya Medical Centre, Kuala Lumpur, Malaysia

INTRODUCTION/BACKGROUND
We present a case of syndrome of inappropriate anti-diuresis (SIAD) as a rare presentation of TSH-secreting pituitary macroadenoma.

CASE
A 57-year-old postmenopausal female with no prior medical illness presented with recurrent admissions for symptomatic hyponatremia associated with abdominal pain and vomiting. She denied symptoms of hypothyroidism or hyperthyroidism. There was no history of medication intake. Family history was unremarkable. She was clinically euvolemic, and never exhibited clinical signs of hypo- or hyperthyroidism. There was no goitre.

Serial investigations showed hyponatremia (nadir of 114 mmol/L) and hypoosmolality (nadir of 257 mmol/kg), with elevated urine sodium (90-153 mmol/L) and urine osmolality (360-600 mmol/kg). Copeptin was elevated at 55.7 pmol/L (normal range: <13.1). Further investigations showed a persistently discordant thyroid function test