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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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.

EP_A048

HYPONATREMIA AND TSHoma: THE ODD COUPLE

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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

(TFT), with elevated free-T4 (range: 24.3-34.3 pmol/L) and non-suppressed thyroid stimulating hormone (TSH) (range: 1.19-4.07 mIU/L), similar across different laboratory platforms. Serum alpha-subunit of TSH was 0.6 IU/L, with TSH molar ratio of 3.1. Morning cortisol level was normal (598 nmol/L). Other pituitary hormones were appropriate for age and postmenopausal status. Whole body CT-scan was negative for malignancy, but incidentally showed a sellar mass. MRI confirmed a sellar mass measuring 1.1 x 2.1 x 2.1 cm, with suprasellar and cavernous extension, and chiasmal compression, with no features of apoplexy. Posterior pituitary T1 bright spot was present and displaced posteriorly.

Her hyponatremia improved with fluid restriction and rescue doses of tolvaptan. The sellar tumour was resected trans-sphenoidally. Histopathological examination confirmed a diagnosis of pituitary adenoma, which stained negative for ACTH, GH and PRL. TSH-staining was unavailable. Postoperatively, her TFT and sodium levels normalized.

CONCLUSION

Hyponatremia is a rare presentation for pituitary adenomas, especially in the absence of hypocortisolism or hypothyroidism. SIAD has been reported in non-functioning pituitary adenomas, pituitary apoplexy and central hypothyroidism and hypocortisolism. This is postulated to be due to exaggerated arginine-vasopressin (AVP) secretion due to local mass effect.

EP_A049

GIANT PITUITARY MACROADENOMA MASKED BY BILATERAL RETINAL DETACHMENT

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INTRODUCTION/BACKGROUND

Pituitary adenomas are benign tumours that encompass 10-20% of intracranial neoplasms. About 25-35% are clinically non-functioning pituitary adenomas (NFPA). Giant pituitary adenomas (diameter ≥4 cm) comprise approximately 5% of all pituitary tumours and usually present with mass effects on the neighbouring structures causing visual impairments, headaches and cranial nerve dysfunction. We present a case of giant pituitary macroadenoma with late presentation, being masked by bilateral retinal detachment.

CASE

A 39-year-old male with past history of bilateral retinal detachment following motor vehicle accident presented with progressive deteriorating vision for the past 3 years. This was initially attributed to retinal detachment/retinal scar. He then had frequent falls and headaches for the past 2 months. Cranial MRI showed a large pituitary adenoma measuring 6.3 x 5.7 x 5.9 cm with compression to the frontal and parietal lobes, optic chiasm and lateral ventricles bilaterally. He underwent two debulking surgeries. Post-surgery imaging showed minimal changes in tumour size. Histopathology examination showed pituitary adenoma with low ki67. Clinically and biochemically, he had panhypopituitarism with thyroid stimulating hormone (TSH), adrenocorticotropic hormone (ACTH) and gonadotrophins insufficiency. He is now on thyroxine, hydrocortisone and testosterone replacement. A multidisciplinary team meeting discussion concluded that a third debulking surgery by a high-volume surgeon followed by radiotherapy is the best option for the patient.

CONCLUSION

This is a case of NFPA complicated by progressive visual impairment which was masked by bilateral retinal detachment. We highlight the difficulty of detecting NFPA early in this patient in view of his visual history.

EP_A050

RESOLUTION OF CYSTIC MACROPROLACTINOMA WITH DOPAMINE AGONIST THERAPY

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INTRODUCTION/BACKGROUND

Cystic prolactinomas are prolactinomas that harbor cystic regions, usually occupying ≥50% of the tumour volume. It is hypothesized that dopamine agonists are ineffective in reducing cystic tumour mass due to the absence of dopamine receptors in the cystic portion of the tumour. We present a case of a patient with a cystic prolactinoma for which the cyst disappears following treatment with dopamine agonist.

CASE

A 23-year-old Malay female first presented with secondary amenorrhoea. She attained menarche at 15 years of age and had regular menses since then until 2019. She is otherwise